**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Toronto Service Area Office**
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
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## Amended Public Report (A1)

**Report Issue Date** October 7, 2022
**Inspection Number** 2022_1525_0001
**Inspection Type**
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
The Governing Council of the Salvation Army in Canada

**Long-Term Care Home and City**
Isabel & Arthur Meighen Manor, Toronto

**Inspector who Amended**
Ivy Lam (646)

**Inspector who Amended Digital Signature**
Ivy Lam
2022.10.12 12:29:29 -04'00'

## AMENDED INSPECTION REPORT SUMMARY

No amendments were made to the public report. The Complaint inspection #2022_1525_0001 was completed on September 2, 2022.

## INSPECTION SUMMARY

The inspection occurred on the following date(s): August 24, 25, 26, 29, and September 1, and 2, 2022.

The following intake was inspected:

- Intake # 007109-22 (Complaint) related to medication reconciliation error and plan of care.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Safe and Secure Home

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## NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)**

**O. Reg. 246/22, s. 24(2)(3).**

The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area in the home.

The long-term care home did not have air conditioning in all residents' bedrooms. Designated cooling areas in the home included hallways, activity rooms, and dining rooms.

The home's Long-Term Care (LTC) Home Temperature Monitoring sheet did not include measurements of activity rooms and dining rooms and all floors.

The Environmental Services Manager (ESM) indicated that the dining rooms and activity rooms were designated cooling areas for residents and should be included on the temperature measurement forms but were not.

On August 29, 2022, the ESM showed the inspector that the LTC Home Temperature Monitoring sheet was updated to include activity rooms and dining rooms on all six units, and the temperature recording of all designated cooling areas began on August 27, 2022.

Later observation and interview of Handyman #115 indicated all designated cooling areas, including dining rooms and activity rooms, were measured as part of the LTC Home three times daily temperature monitoring.

**Sources:** Review of Long-Term Care (LTC) Home Temperature Monitoring Forms; Heat Related Illness Prevention and Management Plan – Policy 3.10; Observations of air temperature measurements; Interviews with the Handyman and the Environmental Services Manager (ESM).

**Date Remedy Implemented:** August 27, 2022

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## WRITTEN NOTIFICATION [LEGISLATIVE SECTION TITLE]

**NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: LTCHA, 2007, s. 6(4)(a)**

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The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident's medication care plan, so that their assessments were integrated and were consistent with and complemented each other.

**Rationale and Summary**

A resident was admitted to the LTC home. The resident was prescribed multiple medications, and their discharge Medication Administration Record (MAR) indicated that the resident continued to require those medications.

The home's medication reconciliation policy indicated that, on admission, the registered staff will write the admission medications noted from the previous facility on the Admission Medication Reconciliation Form (AMRF). Sources of information were to be reconciled and specified on the AMRF. The physician was to review the AMRF to confirm the orders or to make changes; they were to be informed of medications that did not have a source of order, for further examination. If the physician does not order the medication, the 'not ordered' column was to be checked. A second registered staff was to verify the list provided by the resident against the AMRF and sign.

On admission, a Registered Practical Nurse (RPN) prepared the resident's AMRF and was not aware that page one of the resident's MAR was missing. The RPN noted the medications were on certain documentations but not on their discharge MAR. The RPN listed the medication on the AMRF as 'not ordered', before speaking with the physician. The RPN did not endorse to the next shift to verify the resident's medication, and did not contact the physician, the resident's previous facility, or the family for further information when there was a discrepancy between the sources of medication for the resident.

The MD indicated they were not aware of the discrepancy with the resident's medications and would have conducted further assessments if there were any changes to their previous medication regiment. The MD did not speak with the RPN about the resident's medications upon admission and made assumptions about what the RPN had transcribed.

Another RPN, who did the second check on the AMRF, indicated they also did not notice the discrepancy with the resident's medication regimen from the previous facility. They were not sure why there was a discrepancy with the resident's medications from the first RPN and did not see where these medications were listed, but did not contact the first RPN, the MD, the resident's previous facility, or the family for further information.

From admission, a number of the resident's regularly prescribed medications were not ordered or provided for them, and this was done without an assessment by a physician. This was not identified until months later by a specialist.

The MD and the Medical Director indicated the registered staff initializing the AMRF should have called the previous facility to verify any discrepancies from the sources of information, or

contacted the family, or notified the MD or nurse manager, or endorse it to the next shift to follow up, and this was not done.

The Executive Director (ED) indicated the team should have collaborated with the resident admission medication reconciliation by following the process in the home's medication reconciliation policy, and this was not done.

There was a risk to the resident's safety and wellbeing when the staff did not collaborate in the assessment of resident's medication care plan from the resident's admission to the LTC home.

**Sources:** Review of the resident's progress notes, specialist progress notes, Plan of Care Policy, Medication Reconciliation Policy, Resident's discharge Medication Administration Record (MAR), Medication Reconciliation Form, eMAR, Home Care (HC) Assessment form; Interviews with RPNs, physician (MD), the Medical Director, and the Executive Director (ED).

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## WRITTEN NOTIFICATION: 24-HOUR ADMISSION CARE PLAN

**NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 79/10, s. 24(5).**

The licensee has failed to ensure that a resident and their substitute decision-maker (SDM) was given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan for medication.

**Rationale and Summary**

The home's medication reconciliation policy indicated that, on admission, the registered staff would use the AMRF to list admission medications from the previous facility. The families or SDMs were to be consulted for further information regarding these medications.

At the time of the admission medication reconciliation process, a discrepancy was noted with the resident's medication list from their previous facility.

The RPN who prepared resident's AMRF noted a discrepancy. The RPN did not specify on the AMRF whether there was family input related to the resident's medications that were identified as a discrepancy. They stated they did not communicate with the family or SDM during the resident's medication reconciliation process and had not asked for clarification or further information about the resident's medications when there was adiscrepancy between the sources of information for the resident.

A second RPN who did the second check on the AMRF indicated they were not sure why the first RPN saw a discrepancy with the resident's medications but did not contact the resident's SDM or family for further information.

The MD reviewed the AMRF in the resident's physical chart, saw a discrepancy with the medication list and assumed that the medications were previously discontinued, without communicating with the resident's family.

The SDM was unaware that there were medications not provided to the resident until months after admission, when a specialist questioned why the resident no longer received these medications, and why the medications were not on the resident's admission medication reconciliation.

The Medical Director indicated that if there were discrepancies on the sources of order on admission, the registered staff performing the AMDR should contact the family or the previous facility to clarify.

The ED indicated that the SDM should have been given opportunity, in this situation, to participate in the resident's medication reconciliation at admission, and they were not given that opportunity.

**Sources:** Review of the resident's progress notes, Specialist progress notes, Plan of Care Policy, Medication Reconciliation Policy, Resident's discharge MAR, Admission Medication Reconciliation Form, Admission eMAR, Home Care (HC) Assessment form; Interviews with RPNs, the MD, the Medical Director, and the ED.

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## WRITTEN NOTIFICATION: COOLING REQUIRMENTS

**NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22, s.23(3)**

The licensee has failed to ensure that the heat related illness prevention and management plan for the home was evaluated and updated, at a minimum, annually, in accordance with evidence-based practices.

**Rationale and Summary**
Residents' bedrooms were not served by air conditioning in the home. The Fixing Long-Term Care Act, 2021 – Ontario Regulation 246/22, indicates that, for every resident bedroom that is not served by air conditioning, the licensee was to ensure that the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

At the time of inspection, the daily measurement and documentation of all residents' bedrooms not served by air conditioning was not done.

The home's Heat Related Illness Prevention and Management policy did not include directions to ensure that, for every resident bedroom that is not served by air conditioning, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

The ED indicated the policy needed to be evaluated and updated to reflect the current legislation and it was not.

**Sources:** Review of LTC Home Temperature Monitoring Forms; Heat Related Illness Prevention and Management Plan – Policy 3.10; Interviews with the ESM and the ED.

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## WRITTEN NOTIFICATION: AIR TEMPERATURE

**NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22, s.24(4).**

The licensee has failed to ensure that, for every resident bedroom that was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

**Rationale and Summary**
Residents' bedrooms were not served by air conditioning in the home. The home's LTC Home Temperature Monitoring sheet did not include measurements of all residents' bedrooms not served by air conditioning.

The home's Heat related Illness Prevention and Management policy neither specified that the temperature of residents' bedrooms should be measured and documented at the time above, nor who was responsible to do so.

The Handyman and the RPN indicated they did not receive direction to measure the air temperature of all residents' bedrooms that were not served by air conditioning.

The ESM indicated that a form was created for the measurement of temperature of all residents' bedrooms but was still in discussion with the Director of Care (DOC), as the environmental staff would not have time to measure all 168 residents' bedrooms.

The Director of Care (DOC) indicated that it would be the role of the environmental department to measure the temperature, not nursing.

The ED indicated that the temperature of all residents' rooms has not been measured and documented daily between 12 p.m. and 5 p.m., as the home was still in the process to identify who would be able to do the measurement.

There was a risk that timely identification and action would not be provided to ensure residents' comfort and safety would not be provided when the temperature of all residents' rooms not served by air conditioning was not measured.

**Sources:** Review of LTC Home Temperature Monitoring Forms; Heat Related Illness Prevention and Management Plan – Policy 3.10; Observations of residents and residents' bedrooms, observations of air temperature measurement on residents' home areas with handyman; Interviews with a resident, Handyman, RPN, the ESM, the Director of Care (DOC), and the ED.

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## WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

**NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22, s.102(9)(b).**

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in a resident was recorded.

**Rationale and Summary**
A resident had tested positive for an infection. There was no documentation of symptom monitoring for the resident on two shifts.

The Infection Prevention and Control (IPAC) lead and the ED indicated that it was the home's expectation that residents with infection should be monitored and have symptoms documented, and the recording was not done for the resident on the shifts above.

There was a risk that timely response to residents' symptoms of infection would not be communicated, and appropriate actions taken when their symptoms are not recorded on every shift.

**Sources:** Review of the resident's progress notes, Infection Control Surveillance Corrective Actions policy 13.10, Infection Surveillance Monthly Report, Meighen Manor Daily Symptom Surveillance Tool; Interviews with the Infection Prevention and Control (IPAC) lead, ED, and other staff.

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