Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Toronto District
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Original Public Report

Report Issue Date: January 3, 2023	
Inspection Number: 2022-1525-0002	
Inspection Type: Critical Incident System	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: Isabel and Arthur Meighen Manor, Toronto	
Lead Inspector Ryan Randhawa (741073)	**Inspector Digital Signature**
Additional Inspector(s) Wing-Yee Sun (708239)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12-13, 15-16, 19 2022.

The following intake(s) were inspected:

- Intake #00012990 (CIS #3031-000002-22) related to falls
- Intake #00013031 (CIS #3031-000007-22) related improper/incompetent care
- Intake #00013065 (CIS #3031-000034-22) related to alleged abuse
- Intake #00013808 (CIS #3031-000058-22) related to reporting.

The following intakes were completed in this inspection:

- Intake #00002000 (CIS #3031-000043-22) and Intake #00013808 (CIS #3031-000058-22) and Intake #00015440 (CIS #3031-000062-22) were related to falls.

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

Infection Prevention and Control
Resident Care and Support Services

Falls Prevention and Management
Reporting and Complaints
Responsive Behaviours

INSPECTION RESULTS

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

(i) Observations in a Home Area identified a bottle of ABHR containing 60% alcohol, stored in a Personal Protective Equipment (PPE) caddy hanging on a resident's room door.

A Registered Practical Nurse (RPN) acknowledged the ABHR did not contain a minimum of 70% alcohol, and would not be as effective against bacteria and infection prevention.

The 60% ABHR was later removed.

Sources: Observations on December 12, 2022, interview with RPN and other staff.

[708239]

Date Remedy Implemented: December 13, 2022

The licensee has failed to ensure that their hand hygiene program was implemented in accordance with any standard issued by the Director.

Rationale and Summary

Observations on December 12, 13 and 16, 2022 identified seven bottles of expired ABHR in various locations in the home.

Three RPNs and the ESM acknowledged that the bottles of ABHRs were expired, and immediately removed them from use. Two RPNs and the ESM acknowledged that expired ABHR could have decreased effectiveness against viruses and bacteria.

The ESM and the IPAC Support acknowledged they were informed about the expired ABHR and initiated audits in the home. The Executive Director (ED) acknowledged that all expired ABHR were removed and an audit of expired ABHR in the home was completed. The ED acknowledged that ABHR would be audited on a regular basis moving forward.

Sources: Observations on December 12, 13, and 16, 2022, interviews with RPNs, the ED and other staff.

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Date Remedy Implemented: December 16, 2022

WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (3) 4.

The licensee has failed to ensure that a fall that caused an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in their health condition was reported to the Director no later than one business day.

Rationale and Summary

A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) for a fall that occurred in which a resident sustained an injury and resulted in a significant change in their health status.

On a specified date, a resident fell and was unable to weight bear; they were transferred to the hospital. The resident returned to the home the next day and was diagnosed with an injury.

Prior to the incident, the resident ambulated using an assistive device with assistance. After the incident the resident required a different assistive device and a specialized device. The resident passed away seven days later.

The Director of Care (DOC) acknowledged that the critical incident should have been submitted to the Director once the injury was confirmed.

There was low impact and risk of harm to the resident when reporting requirements were not met.

Sources: CIS report #3031-000002-22; resident's progress notes; and interview with the DOC.

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WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that a resident, who demonstrated responsive behaviours, had strategies implemented to respond to these behaviours.

Rationale and Summary

A resident had a history of resistance during care. Staff developed interventions, including the Stop and Go approach, where staff were directed to walk away and reapproach after five to ten minutes.

The PSW acknowledged they were aware of the Stop and Go approach but did not follow the

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intervention.

The Behavioural Support Ontario (BSO) Lead acknowledged that staff should consider the Stop and Go approach if the resident was not receptive to care. They acknowledged that if staff proceeded with care for the resident without their agreement, the resident's behaviours could be increased. They acknowledged that the Stop and Go approach was not attempted and this intervention set out in the written plan of care was not implemented.

Sources: Resident's written plan of care, interviews with PSW and BSO Lead.

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