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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 21, 2023	
Original Report Issue Date: August 15, 2023	
Inspection Number: 2023-1525-0004 (A1)	
Inspection Type: Complaint 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	
Amended By Nital Sheth (500)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to correct an error of Non-Compliance (NC) numbering.

Ministry of Long-Term Care
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Lead Inspector Nital Sheth (500)	**Additional Inspector(s)** Nicole Ranger (189) Yannis Wong (000707)
Amended By Nital Sheth (500)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

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INSPECTION SUMMARY

The inspection occurred on the following date(s): July 12, 13, 14 (off-site), 17, 18, 19, 20, 21, 24, 25, 31 (off-site), August 1 (off-site), 2023.

The following intake(s) were inspected:
- A complaint intake #00090264 related to duty to protect
- A complaint intake #00090482 duty to protect from the Personal Support Worker (PSW)

from an agency
- A complaint intake #00091753 related to missing information on the home's website
- Intake #00090364 related to the elopement of a resident
- Intake #00090409 related to duty to protect from an individual posing as a PSW
- Intake #00090504 related to a fall incident of a resident resulting in injury
- Intake #00090749 related to unsafe transfer resulting in injury
- Intake #00091019 related to duty to protect and improper care
- Intake #00091186 related to duty to protect, improper care, continence care, dining, and snack service, falls prevention and management, and palliative care

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENT BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee has failed to ensure that Personal Support Worker (PSW) #112 and #114 treated resident #004 with respect and dignity.

Rationale and Summary
A video footage provided by resident #004's Substitute Decision Maker (SDM) to the Ministry of Long Term Care (MLTC), indicated that PSW #112 and #114 treated the resident disrespectfully.

Another video footage provided by the SDM indicated that three staff members talked about the resident's personal health information disregarding the resident's presence in the room.

The Physiotherapist (PT) and Director of Care (DOC) verified that the staff failed to treat the resident with respect and dignity after watching the video footage.

Failing to treat the resident with respect and dignity put the resident at risk of emotional harm.

Sources: A review of the plan of care, video footage, interviews with SDM, PT, DOC and other staff members. [500]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care has clear directions to staff regarding a specified care for resident #003.

Rationale and Summary
Resident #003 has a history of responsive behaviour. The resident's plan of care included a specified intervention to address their responsive behaviour. The specified intervention was inconsistent across the resident's care plan including progress notes, and paper documents.

During interviews with Registered Practical Nurse (RPN) #134, #133, the Behavioural Supports Ontario (BSO) Lead reviewed the care plan and acknowledged the specified intervention being inconsistent and unclear in the resident's plan of care.

Failure to have clear directions in the plan of care can result in direct care staff implementing the specified intervention for resident #003 inappropriately, resulting in potential risks to their safety.

Sources: Critical Incident System (CIS) report; clinical records; interviews with RPN #133, RPN #134, BSO Lead, and DOC. [000707]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan.

Rationale and Summary
Resident #004 was at high risk for falls. The resident's care plan directed the staff to apply a specified intervention.

The PT's note indicated that staff was to apply the specified intervention. The resident had a fall incident. RPN #111 and PSW #113 verified that the resident's specified intervention was not applied at the time of the fall.

Video footage provided by resident #004's SDM to the MLTC, indicated that staff members failed to apply the specified intervention to the resident.

The PT and DOC verified that the staff were required to follow the resident's plan of care.

Failure to apply the specified intervention placed the resident at risk of potential injury.

Sources: A review of the plan of care, video footages, and interviews with resident #004' SDM, PT, DOC, and other staff members. [500]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident #005 was protected from verbal abuse by PSW #122.

O. Reg 246/22, s. 2 (1) verbal abuse as "any form of verbal communication of a threating or

intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Rationale and Summary
RPN #121 was reported by the family member of resident #005, stating that abuse happened by agency PSW #122 which was captured on camera footage.

A review of the video surveillance revealed that agency PSW #121 provided specified care to the resident. During the care, agency PSW #121 spoke to the resident in loud and belittling manner. The PSW continue to provide care to the resident, to which the resident was seen resisting and made threatening comments to the resident. The resident was heard apologizing to the PSW.

The DOC stated the incident caused shame and hurt the feelings of the resident and acknowledged that the actions PSW #122 displayed to the resident constituted verbal abuse.

Failure of the home to prevent staff to resident verbal abuse placed the resident at risk of emotional harm.

Sources: Review of resident #005's care plan, home's investigation notes, CIS report, compliant intake #00090482, video footage, interview with DOC, RPN #121 and other staff. [189]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that anyone who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported to the Director.

Rationale and Summary

A CIS report was submitted to the Director on related to improper or incompetent treatment or care that resulted in harm to resident #002.

The DOC became aware of the incident on the date it was reported to the Director.

The DOC stated that an investigation was conducted on that date the incident was reported to the Director, where they identified that a week prior, PSW #114 provided a specified care to the resident and as a result, the resident sustained a significant injury.

The DOC reported that the incident was not initially reported to them when an incident a week prior occurred, however, the staff were required to report this, as this would have been the expectations.

Failure of the home to immediately report the improper treatment of the resident could have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Review of progress notes, CIS report, the home's investigation notes, interview the DOC. [189]

WRITTEN NOTIFICATION: TRAINING

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee has failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned under this legislative section.

Rationale and summary
As defined in FLTCA, 2021, s. 80(2), "agency staff' means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. In accordance with FLTCA, 2021, s. 80 (3), a staff member who is agency staff, is considered to be hired when they first work at the home.

Record review of agency staff was completed for PSWs #123, #124, #125 and #126 and indicated the following:

- PSW #123 began working at the home January 2023
- PSW #124 began working at the home June 2023
- PSW #125 began working at the home February 2023
- PSW #126 began working at the home March 2023

PSW #123 and #126 did not receive training on the required areas as defined in the legislative reference under FLTCA, 2021, s. 82 (2), prior to the start of working in the home. PSW #124 and PSW #125 was enrolled in the Surge Learning program in July 2023. PSW #124 completed the training 18 days later and PSW #125 completed the training four days later.

The Executive Director (ED) indicated all training requirements for the agency employees were completed on an online system called Surge Learning.

The ED acknowledged that the agency staff did not receive the online training as required.

Failure of the staff receiving training placed the residents at potential risk of incompetent care and treatments.

Sources: Record review of agency training records. interviews with the ED, Agency Chief Executive Officer (CEO) and Office Manager. [189]

WRITTEN NOTIFICATION: RESPOSIVE BEHAVIOURS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that actions taken to respond to the needs of residents demonstrating responsive behaviours, including assessments were documented for resident #001.

Rationale and Summary
Specifically, an interpretation assessment was not completed for the responsive behaviour intervention, Behavioural Support Ontario-Dementia Observation System (BSO-DOS) Data Collection Sheet.

BSO-DOS is a paper-based tool and documented by direct care staff at a specified frequency. When the BSO-DOS observation is complete, the Behavioural Support Ontario Lead (BSO Lead) completes the BSO assessment by reviewing the observation tool and identifying what may trigger a resident's responsive behaviours.

Resident #003 exhibited a responsive behaviour. As a result of an incident, RPN #128 initiated BSO-DOS monitoring. After the observation period, the BSO Lead did not complete the BSO assessment.

The BSO Lead was not aware BSO-DOS monitoring was initiated for resident #003. The BSO Lead was away and did not receive a referral for follow up. The BSO Lead and DOC acknowledged that the BSO-DOS monitoring interpretation assessment should have been completed.

Failure to complete the analysis assessment can result not identifying triggers or times of responsive behaviour and subsequent appropriate interventions.

Sources: Resident #003's BSO-DOS data collection sheet; clinical records; interviews with BSO Lead and DOC. [000707]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND COTROL (IPAC)

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

Rational and Summary
The video footages provided by resident #004's Substitute Decision Maker (SDM) to the Ministry of Long Term Care (MLTC), indicated that PSW #112 and #114 wore the same pair of gloves and completed multiple tasks for resident #004.

The IPAC Lead verified after watching the video footages, that staff should have removed their gloves and performed hand hygiene in between the tasks.

Failing to follow IPAC practices, the staff increased a risk of cross contamination in the home.

Sources: Video footages, Interviews with IPAC Lead and other staff. [500]

WRITTEN NOTIFICATION: VISITOR POLICY

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (2)

The licensee has failed to ensure that the visitor log included the name and contact information of the visitor, and the name of the resident visited as outlined in O. Reg 246/22 s. 267 (2).

Rationale and Summary
A review of the home’s Visitor Log from a period in June to July 2023, identified the following missing requirements:
- Multiple entries where Full name (first and last name) of visitors were incomplete
- No entry for contact information of the visitor
- Multiple entries where the name of the resident visited were incomplete

The ED acknowledged that the visitors log did not include the above requirements.

Sources: A review of intake #00091753, Visitor's Log for June and July 2023, interviews with ED and Receptionist. [189]

WRITTEN NOTIFICATION: WEBSITE

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1)

The licensee has failed to ensure the home's website that is open to the public includes the minimum requirements as outline in O. Reg 246/22 s. 271 (1).

Rationale and Summary
The licensee had failed to identify on their website the following information:
- Direct contact information, including a telephone number and email address that are monitored regularly for the licensee or a senior office of the licensee; the Executive Director; the Director of Care; the Infection prevention and Control Leads for the home
- The Ministry of Long Term Care toll-free telephone number for making complaints about the home
- The current continuous Quality Improvement Initiative report for the home made under subsection 168 (1) and
- The current version of the Visitors policy made under section 267
- the current version of the emergency plans for the home as provided for in section 268

The ED acknowledged that the website did not include the above identified requirements.

Sources: Review of the Isabel and Arthur Meighan Manor public website, intake #00091753, interview with the ED. [189]

COMPLIANCE ORDER CO #001 ACCOMODATION SERVICES

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:
1. Complete an audit of all windows accessible to residents in the home to ensure they are in a good state of repair, have a screen, and cannot be opened more than 15 centimeters.
2. Identify windows with issues and complete the required repairs, including, but not limited to, the identified resident rooms.
3. Ensure all windows (including six identified resident rooms) are equipped with an operating window handle unless there are care plan interventions based on the resident's individual assessment.
4. Develop and implement a schedule and procedure for audits to ensure all windows accessible to residents are maintained in a good state of repair.

5. Maintain a record of audits; including who conducted audit, time and date, location, and actions taken in response to audit.

Grounds
The licensee has failed to ensure that the home and equipment were maintained in a good state of repair.

Rationale and Summary
Specifically, multiple resident rooms had a broken window stopper and missing the operating window handle.

The home submitted a CIS report about resident #003's responsive behaviour. Resident #003 had a history of responsive behaviours and related incidents. The resident had an incident of responsive behaviour as a result of a disrepair in their co-resident's window and the window was able to open wider than 15 cm. The home had a window stopper in each residents' room window, which was a safety mechanism that prevents the window from opening wider than 15 centimeters (cm). The home conducted an audit and identified that the window stopper in another resident's room was also broken and would be replaced at the same time.

During the inspection, multiple observations were conducted on resident room windows with Handyman #119 and the Environmental Service Manager (ESM). The window stopper remains broken in an identified room, and the ESM measured the window opening at 19 cm. The inspector identified a broken window stopper in another room, and the ESM measured the window opening at 18.5 cm.

Additionally, the operating window handle was missing on multiple resident room windows.

Resident #008 expressed to the inspector and ESM that they need an operating window handle to open and close their window. PSW #118 informed maintenance about an issue with resident #008's window, two weeks prior to the inspection.

A review of resident #008's progress notes indicated maintenance requests were sent on two identified days in two months about a broken operating window handle in the resident's room and the window could not be closed. Resident #007's operating window handle had been missing for several weeks and the SDM was not informed of the reason for removal.

The DOC, Handyman #119, and the ESM were unaware of the missing operating window handles in multiple resident rooms, including, four identified rooms. The operating window handle in two identified rooms were removed as a temporary measure to keep the window closed until the repair was completed.

The ESM stated there was no schedule for window audits, at the time of this inspection. When any issues arise with windows, staff notify the maintenance department, and the ESM contacts the contractor for repair.

Failure to ensure the window stoppers were in a good state of repair pose safety risks for all residents on the secure unit and resulted in resident #003's incident of responsive behaviour.

Sources: CIS report, observations, the home's investigation notes, resident #003 and resident #008 clinical records, interviews with resident #008, visitor #130, PSW #118, DOC, Handyman #119, and ESM. [000707]

This order must be complied with by September 15, 2023

COMPLIANCE ORDER CO #002 SAFE TRANSFERRING AND POSITIONING TECHNIQUES

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
on-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Educate PSW #106 on the home's Zero Lift Policy.
2. Educate RPN #105 on transferring a resident post-fall, and the home's Zero Lift Policy.
3. Educate all staff working on the identified resident home area on resident #004's plan of care related to the resident's transferring and positioning requirements.
4. Maintain a record of the education, including the content, date, signatures of staff who attended and the staff member who provided the education.
5. Conduct random audits of staff provision of transferring assistance to residents including

PSW #106 and PSW #114 on day and evening shifts for a period of three weeks.
6. Maintain a record of audits completed, including but not limited to, date of audit, person completing the audit, staff and resident audited, outcome and actions taken as a result of any deficiencies identified.

Grounds
1). The licensee has failed to ensure that staff used safe transferring techniques after resident #001 sustained a fall.

Rationale and Summary
Resident #001 was walking in the hallway and had an unwitnessed fall. PSW #106 found the resident on the floor and RPN #105 assessed the resident. They found the resident with pain and injury. PSW #106 and RPN #105 then manually transferred the resident from the floor. RPN #105 notified RN #103 for further assessment, where they noted the resident was showing pain with movement, and the resident was transferred to the hospital. The resident underwent further treatment and sustained a significant change in their health status.

The PT and DOC stated since the resident had pain, injury post fall, and they should not have been moved until the paramedics came.

Both PSW #106 and RPN #105 were unaware of the home's Zero Lift policy, which stated there should be no manual resident lifts. RPN #103 acknowledged they should not be manually lifting the residents.

The PT and DOC acknowledged the manual transfer of resident #001 was inappropriate and the staff members did not follow the home's Zero Lift policy.

Failure to ensure that PSW #106 and RPN #105 used a safe transferring technique placed resident #001 at risk of further injury.

Sources: CIS report; resident #001's clinical records; the home's policy (11-9.30: Zero Lift Policy); interviews with PSW #106, RPN #105, PT, and DOC. [000707]

2). The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #002.

Rationale and Summary
PSW #114 provided care for resident #002 during their shift.
Resident #002 required a type of assistance for transferring. PSW #114 reported that during their shift, the resident requested for care, and they transferred the resident twice without following the proper assistance they require. PSW #114 reported that during the transfer, resident #002 lost their balance and they noticed the resident had an injury. PSW #114 informed RPN #111 of the incident. RPN #111 and Nurse Designate #120 assessed the resident for their injury.

The DOC stated that the home investigated the incident and acknowledged that PSW #114 did not transfer the resident according to their plan of care.

Failure to use safe transferring techniques when assisting resident #002, placed the resident at actual harm of injury.

Sources: Resident #002's clinical records, the home's internal investigation notes, CIS report, and interviews with PSW #114, RPN #111, Nurse Designate #120 and DOC. [189]

3). The licensee has failed to ensure that staff used safe transferring and positioning techniques for resident #004.

Rationale and Summary
The resident's care plan indicated that they have pain related to their health condition. The resident required assistance with transferring. Staff were to transfer the resident in a specified way.

A video footage sent by the SDM indicated that PSW #114 did not transfer the resident in the specified way.

The PT, and DOC verified that the staff should have transferred the resident the specified way as per their plan of care after watching the video footage.

There was potential risk for pain while the staff transferred the resident and failed to use safe transferring and positioning techniques.

Sources: A review of the plan of care, video footages, and interviews with resident #004' SDM, PT, DOC, and other staff members.[500]

This order must be complied with by September 15, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.