Ontario

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

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

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

Original Public Report

Report Issue Date: March 7, 2024	
Inspection Number: 2024-1525-0001	
Inspection Type: Critical Incident	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: Isabel and Arthur Meighen Manor, Toronto	
Lead Inspector Cindy Ma (000711)	**Inspector Digital Signature**
Additional Inspector(s) Henry Chong (740836)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): February 5-9, 12-14, 2024.

The following intake(s) were inspected:
• Intake: #00099546 - [Critical Incident (CI): 3031-000069-23] was related to neglect
• Intake: #00101415- [CI: 3031-0000075-23] was related to external feed
• Intake: #00101490- [CI: 3031-000076-23] was related to neglect and improper care
• Intake: #00102827- [CI: 3031-000080-23] was related to fall with injury
• Intake: #00103697- [CI: 3031-000086-23] was related to improper care and fall with injury
• Intake: #00104345 - [CI: 3031-000087-23]; Intake: #00105920 – [CI: 3031-000003-24] and Intake: #00106871 [CI: 3031-000007-24] were related to

infection prevention and control.
• Intake: #00106074 [CI: 3031-000004-24] was related to improper care.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking requirements were not followed by two staff.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023; all staff, students, volunteers, and support workers wear a medical mask in all resident home areas.

Rationale and Summary
A staff was observed speaking to a resident within one meter distance without a medical face mask on a resident home area. The staff acknowledged they were required to wear a face mask. On the same day, a second staff was observed on a resident home area without a medical mask. This staff stated that they forgot to don a face mask prior to entering the resident's home area. The staff acknowledged they were required to wear a face mask.

The Infection Prevention and Control (IPAC) Lead confirmed that all staff must wear a face mask when inside the resident's home area at all times.

Staff's failure to appropriately don a face mask inside resident home areas increased the risk of infection transmission to residents, other staff and visitors.

Sources: Inspector's observations; interviews with the IPAC Lead and other staff; and Minister's Directive: COVID-19 response measure for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario.
[000711]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure any standard or protocol issued by the Director with respect to IPAC was implemented. Specifically, the licensee failed to ensure that point-of care signage indicating that enhanced IPAC control measures were in place, as required by Additional Precautions 9.1 (e) under the IPAC standard.

Rationale and Summary
A staff was observed inside a resident's room on droplet/contact precautions. A droplet/contact precautions sign was posted on the door indicating the specific personal protective equipment (PPE) to be worn by staff, including eye protection. The staff wore an N95 mask, gloves, and gown, but did not wear eye protection.

A Registered Practical Nurse (RPN) stated that the resident was on contact precautions, and that the signage on the door was incorrect. The IPAC Lead stated that the sign should have indicated that resident was on contact precautions.

Incorrect point-of-care signage for enhanced IPAC control measures may lead to staff wearing inappropriate PPE.

Sources: Inspector's observations, and interviews with RPN and the IPAC Lead. [740836]

COMPLIANCE ORDER CO #001 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

The licensee shall:

1. Ensure residents' plan of care are followed related to provision of personal hygiene assistance by a PSW;
2. Conduct, at minimum, one audit of residents who require one person constant supervision and physical assistance for care performed by the PSW listed in (#1) on each shift worked for a period of two weeks following the service of this order, with different residents audited each day;
3. Maintain a record of the 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

The licensee has failed to ensure that the care set out in three residents' plan of care were provided to the resident as specified in the plan.

Rationale and Summary

(i) A resident was assisted with personal hygiene by a PSW, when they left to assist another resident. The resident had an unwitnessed fall, resulting in an injury. The resident became verbally unresponsive later that day and was transferred to hospital. The resident was diagnosed with a health related issue and subsequently passed away.

The resident's plan of care indicated that they required one person constant supervision with physical assist related to personal hygiene.

Two staff stated that the resident required one person assistance, and that the resident should not have been left alone as they were at risk for falls. The Director of Care (DOC) confirmed that the directions in the resident's plan of care were not followed.

Failure to provide constant supervision and physical assistance to the resident resulted in fall and injury.

Sources: Resident's clinical records; home's investigation notes; and interviews with PSW, RN and DOC.

[740836]

Rationale and Summary

(ii) A resident's plan of care specified a treatment to be delivered to the resident within a schedule time period.

On a specified date, progress notes indicated that the treatment was not provided as scheduled. The resident received approximately eight hours of additional treatment. This was also confirmed by an RPN.

The RPN and the Assistant Director of Care (ADOC) both acknowledged that registered staff failed to provide the resident the required treatment.

Failure to provide the resident the required treatment as specified in the resident's plan of care put the resident at risk of harm.

Sources: Resident's clinical records; and interviews with RPN and ADOC.

[000711]

Rationale and Summary

(iii) A resident's progress notes indicated they required a specific intervention at all times.

The resident was observed not wearing the specific intervention. A PSW indicated that the resident required the specific intervention only at bedtimes.

Failure to apply the specific intervention put the resident at risk for skin breakdown.

Sources: Resident's clinical records; Inspector's observation; and interviews with PSW.

[000711]

This order must be complied with by

April 10, 2024

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

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.