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

Original Public Report

Report Issue Date: June 25, 2024
Inspection Number: 2024-1525-0002
Inspection Type: Critical Incident Follow up
Licensee: The Governing Council of the Salvation Army in Canada
Long Term Care Home and City: Isabel and Arthur Meighen Manor, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7-10, 13-17, 21-24, 27, 2024

The following Critical Incident System (CIS) intake(s) were inspected:
- Intake: #00109977 [CI: 3031-000009-24] and Intake: #00111914 [CI: 3031-000016-24] - Resident to resident physical abuse
- Intake: #00112533 [CI: 3031-000019-24] - Improper care
- Intake: #00113182 [CI: 3031-000024-24] - Fall prevention and management
- Intake: #00113959 [CI: 3031-000026-24] - Improper care and neglect
- Intake: #00115171 [CI: 3031-000030-24] - Infection prevention and control
- Intake: #00116787 [CI: 3031-000035-24] - Unexpected death

The following follow-up intake was inspected:
- Intake: #00110867 - Related to plan of care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were closed:
Order #001 from Inspection #2024-1525-0001 related to FLTCA, 2021, s. 6 (7) inspected by Henry Chong (740836).

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect in a way that fully recognized their inherent dignity, worth and individuality, was fully respected and promoted.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director related to a complaint of improper care to a resident. Review of camera footage indicated that a staff member addressed a resident inappropriately multiple times during care. The home's investigation notes revealed that another staff member addressed the resident inappropriately during care.

Two staff members confirmed that they addressed a resident inappropriately during care despite being trained by the home. A Registered Practical Nurse (RPN) stated

they've noticed that staff had addressed the resident inappropriately and they had notified them of the home's expectation. The Assistant Director of Care (ADOC) indicated that the residents should be appropriately addressed.

Failure to not address the resident appropriately put them at risk of not being treated with respect and dignity.

Sources: CI report #3031-000019-24; investigation notes and camera footages; resident's clinical records; and interviews with ADOC, and other staff.

[741672]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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 to review their medical record results and implement treatment in a timely manner.

Rationale and Summary
A CI report was summitted to the Director related to a resident's improper care due to missing medical record results, which led to delayed treatment. The resident's medical results were faxed to the Long Term Care (LTC) Home several days later, however the results were not found and reviewed by staff until several weeks later. The resident was not treated for approximately three weeks as the results were missing.

Multiple staff indicated that they did not follow up on the results and there was a lack of communication when it was received by the home, between staff members.

The ADOC indicated that the resident's medical records should have been reviewed by the registered nurse as soon as it was faxed to the home and the physician should have been informed immediately about the resident's results, so that they could have ordered treatment earlier. They also stated that there was no collaboration between the staff to ensure the resident's results were reviewed and treatment implemented in a timely manner.

Due to not collaborating with each other, staff members failed to review the resident's medical record results and treat them in a timely manner which put the resident at risk of a worsening health status.

Sources: CI report #3031-000026-24; resident's clinical records; and interviews with the ADOC, and other staff.

[741672]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that a PSW who provided direct care to a resident was kept aware of the contents of the resident’s plan of care.

Rationale and Summary
A CI report was submitted to the Director related to a complaint of improper care to a resident. Review of the camera footage indicated that the resident's plan of care was not followed. The home's investigation notes indicated that the PSW was not aware of the resident's plan of care, and they did not review the resident's written care plan prior to care.

The PSW confirmed that they were not aware of the resident's health status and did

not review their plan of care. The ADOC confirmed that the PSW should have reviewed the resident's plan of care prior to the care since they were not aware of their care needs.

Failure of the PSW being aware of resident's plan of care put them in pain and risk of injury.

Sources: CI report #3031-000019-24; home's investigation notes; resident's observation and clinical records; and interviews with PSW and ADOC.

[741672]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs changed.

Rationale and Summary
A CI report was submitted to the Director related to the unexpected death of a resident following an incident. The resident's plan of care indicated that staff should implement specific interventions when the resident was eating. Review of camera footage revealed that the interventions in their care plan were not implemented.

Multiple staff indicated they did not implement the interventions when the resident was eating. Behavioural Supports Ontario (BSO) lead indicated that as per the resident's care plan, the interventions should have been implemented to ensure the resident was eating safely. Registered Dietitian (RD) indicated that they had not

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assessed the resident at a specific mealtime and did not consider in their assessment changes in the resident's needs. The resident's plan of care was not revised based on their needs changing. The DOC confirmed that the resident's plan of care should have been reviewed and revised when they recognized that the resident's care needs changed. They also indicated that specific interventions should have been reflected on the resident's care plan.

Failure to revise the resident's care plan during meals put the resident at risk of choking.

Sources: CI report #3031-000035-24; camera footages; resident's clinical records; and interviews with BSO lead, and other staff.

[741672]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the information to the Director when they had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident.

Rationale and Summary
A CI report was summitted to the Director related to a resident's improper care. The incident was reported to the Director several days later.

The ADOC confirmed that the incident should have been reported to the Director immediately.

There was no harm to the resident related to the late reporting.

Sources: CI report #3031-000026-24; resident's clinical records; and interview with ADOC.

[741672]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the information to the Director when they had reasonable grounds to suspect abuse of resident #002 by resident #001 that resulted in a risk of harm to resident #002.

Rationale and Summary
On an identified date, staff discovered resident #001 and resident #002 in a physical altercation. The home submitted a CI report to the Ministry of Long-Term Care several days later.

A Registered Nurse (RN) stated that they did not report the incident immediately to the Director. The ADOC said that the incident should have been reported immediately using after-hours reporting system and confirmed that the CI report was submitted several days later.

Sources: CI report #3031-000016-24; and interviews a RN and ADOC.

[740836]

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when resident #001 and resident #002 were demonstrating responsive behaviours, that actions were taken to respond to the resident's needs, including assessment, reassessments, interventions, and that the resident's responses to interventions were documented.

Rationale and Summary
i) Resident #001 and resident #002 were involved in a physical altercation. The Behavioural Supports Ontario - Dementia Observation System (BSO-DOS) monitoring tool was initiated for resident #001 for a period of five days related to responsive behaviours.

The BSO-DOS monitoring tool was not documented on multiple shifts during the course of two days.

The BSO Lead and ADOC both stated that the BSO-DOS monitoring tool was to be documented for all shifts indicated and that it was not completed in its entirety.

Failure to document on the BSO-DOS monitoring tool in its entirety resulted in missing information when analyzing trends related to resident #001's responsive behaviours.

Sources: Resident #001's BSO-DOS monitoring tool; and interviews with BSO Lead and ADOC.

[740836]

ii) Resident #001 and resident #002 were involved in a physical altercation. The BSO-DOS monitoring tool was initiated for resident #002 for a period of five days related to responsive behaviours.

The BSO-DOS monitoring tool for resident #002 was not documented on multiple shifts during the course of two days.

The BSO Lead and ADOC both stated that the BSO-DOS monitoring tool was to be documented for all shifts indicated and that it was not completed in its entirety.

Failure to document the on the BSO-DOS monitoring tool in its entirety resulted in missing information when analyzing trends related to resident #002's responsive behaviours.

Sources: Resident #002's BSO-DOS monitoring tool; and interviews with BSO Lead and ADOC.

[740836]

WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that a RPN used proper and safe feeding techniques when assisting a resident.

Rationale and Summary
A resident's care plan indicated that they required assistance with feeding. During

review of home's camera footage, a RPN was observed feeding the resident using improper and unsafe feeding techniques.

The RPN stated that specific equipment was not available during feeding, however the equipment was available upon review of the footage. The DOC confirmed that all staff feeding residents were supposed to use proper and safe feeding techniques.

Failure to use proper feeding techniques with residents may put them at risk of aspiration with their meal.

Sources: Resident's care plan; home's camera footages; and interviews with a RPN and DOC.

[741672]

WRITTEN NOTIFICATION: Reporting critical incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to immediately report to the Director an unexpected death of a resident.

Rationale and Summary
A CI report was summitted to the Director related to a resident's unexpected death. The home did not contact the Service Ontario after hours line immediately to report the incident.

A staff member who was present at the time of incident confirmed that they missed calling the after hours line to immediately report the incident.

There was no harm to the resident due to the late reporting.

Sources: CI report #3031-000035-24; resident's clinical records; and interviews with staff.

[741672]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Re-educate a dietary aide, PSW, and RPN, on different types of diet textures and the content of the diet texture-International Dysphagia Diet Standardisation Initiative (IDDSI) reference.
2. Conduct random audits, for a minimum of three weeks following the service of this order, of all three meal services (breakfast, lunch and dinner) on a specific home area to ensure residents' diet instructions are being provided as ordered.
3. Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training.
4. Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken.

Grounds

The licensee has failed to ensure that food service workers and other staff assisting a resident were aware of the resident’s diet, and was followed.

Rationale and Summary
A CI report was submitted to the Director related to the unexpected death of a resident. The resident's care plan indicated that staff should follow specific interventions to support safe eating during meals. The diet texture IDDSI reference indicated that an identified food size requirement should not be bigger than a specific size. The home's camera footage revealed that a PSW served food to the resident without following the specific intervention.

A dietary aide stated that they did not follow the specific intervention as they thought the PSWs were responsible. The Food Service Manager stated that the dietary aide was responsible to be aware of the resident's diet as per their care plan, therefore dietary aide should have completed the intervention as per the diet texture IDDSI reference definition. The Registered Dietitian stated that staff should ensure the intervention was completed and followed the diet texture IDDSI reference guideline. A RPN was not aware of the specific size requirement according to the IDDSI guideline. The DOC confirmed that the manner in which staff had provided the food for the resident was not acceptable as they did not follow the diet texture IDDSI reference.

Staff failure to provide the resident food as per diet texture in IDDSI reference definition put the resident at risk of choking and subsequent death.

Sources: CI report #3031-000035-24; camera footages; diet texture IDDSI reference; resident's clinical records; and interviews with DOC and other staff.

[741672]

This order must be complied with by July 19, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Re-educate a PSW on the home's Barrier Protection Policy, more specifically on changing gloves between different tasks during residents' care;
2. Re-educate a RPN on the home's hand hygiene policy and four moments of hand hygiene;
3. Conduct random audits for a minimum of three weeks following the service of this order, on the PSW's practice of changing gloves during care.
4. Maintain a record of the aforementioned training, including the dates, staff names and designation, signed attendance, training topics, and name and title of the person(s) who provided the training;
5. Maintain a record of the aforementioned audits, including the dates and times of the audits, the name(s) of the auditor, the names and designation of staff audited, results of audits and actions taken in response to the audit findings.

Grounds
The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023, was implemented related to improper use of Personal Protective Equipment (PPE) and hand hygiene.

i) The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 (d), that at minimum Routine Practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal. The home's Barrier Protection Policy indicated that "Gloves were single use and should be changed between tasks on the same resident and/or between residents."

Rationale and Summary
A CI report was submitted to the Director related to a complaint of improper care to a resident. Review of camera footage indicated that a PSW did not change their

gloves at any point during provision of care to a resident.

The IPAC lead and ADOC both confirmed that the PSW's practice related to not changing gloves between tasks during care was not acceptable and they were required to change their gloves after each task was completed.

Failure to change gloves between tasks during care for a resident put them at risk of infection.

Sources: CI report #3031-000019-24; investigation notes and camera footages; home's Barrier Protection Policy; and interviews with ADOC and IPAC lead.

[741672]

ii) The IPAC Standard for Long-Term Care Homes indicated, under section 9.1 (b), that at minimum, Routine Practices including hand hygiene were followed, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
On an identified date, a RPN was observed administering medication to a resident and hand hygiene was not completed before and after administration of the medication.

The RPN confirmed that they did not complete hand hygiene before and after administering the medication to the resident. The IPAC Lead said that staff were expected to follow the four moments of hand hygiene, and that there was risk in spread of infection to other residents when hand hygiene was not completed.

Sources: Observations; and interviews with a RPN and IPAC Lead.

[740836]

This order must be complied with by July 19, 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.