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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: October 24, 2022	
Inspection Number: 2022-1491-0001	
Inspection Type: Critical Incident System	
Licensee: Fairview Mennonite Homes	
Long Term Care Home and City: Fairview Mennonite Home, Cambridge	
Lead Inspector Robert Spizzirri (705751)	**Inspector Digital Signature** Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2022.10.24 13:29:49 -04'00'
Additional Inspector(s) Daniela Lupu #758 Henry Chong #740836 Kaitlyn Puklicz #000685 and Mark Molina #000684 were present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 11-14 and 17-18, 2022

The following intake(s) were inspected:

Intake #00003916, #00005759, and #00006608 related to falls prevention and management.

The following intakes were completed in the Critical Incident System Inspection:
Intake #00001804, and #00002687 were related to fall prevention and management.

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

Falls Prevention and Management
Infection Prevention and Control

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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)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), the licensee was required to ensure that the personal protective equipment (PPE) requirements set out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022) was complied with.

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022) required the licensee to ensure that all staff interacting within 2 metres of a resident with suspect or confirmed COVID-19 wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator (or approved equivalent) as appropriate personal protective equipment (PPE).

Rationale and Summary

A resident was isolated for suspected COVID-19. There was signage posted at the entrance of the resident's room indicating the precautions in place.

A staff member entered the resident's room without wearing gloves and a gown. They were observed within two metres of the resident.

The staff member said that they were to only wear gloves and a gown when providing care.

The Director of Care acknowledged that staff were to wear all available PPE, including gloves and a gown when within two metres of the resident.

Failure of staff to wear appropriate PPE increases the risk of transmission and could have put other residents at risk of harm.

Sources: Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022), observations, and interview with DOC and other staff.

[705751]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 a resident's plan of care for falls prevention was followed.

Rationale and Summary

A resident was at risk for falls. Their plan of care had specific interventions in place that staff were expected to follow.

During the inspection it was observed that multiple interventions were not in place as required.

Multiple staff were interviewed and had acknowledged the resident's plan of care was not followed.

Gaps in implementation of interventions set out in the plan of care increased the resident's risk for falls and injury.

Sources: observations of the resident, resident's care plan and other relevant documents, and interviews the DOC and other staff.

[758]

WRITTEN NOTIFICATION: General Requirements

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that a resident's interventions were documented as required.

A resident was at risk for falls. Their plan of care required staff to document an intervention at a specific frequency.

Clinical records showed that staff were not documenting the intervention as required.

Staff interviewed acknowledged that the intervention was not documented appropriately.

Failing to ensure that the documentation of the intervention at the required frequency increased the risk that the effectiveness of the intervention could not be evaluated.

Sources: resident's care plan and other relevant clinical documents, and interviews with the DOC and other staff.

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