Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_370162_0010	024752-15	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

FAIRVIEW NURSING HOME
14 CROSS STREET TORONTO ON M6J 1S8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

TIINA TRALMAN (162), ARIEL JONES (566), JUDITH HART (513), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 11, 14, 15, 16, 17, 18, 21, 22, 28, 29, and 30, 2015.

During the resident quality inspection (RQI) the inspectors conducted an initial tour of the home, dining observation, reviewed resident health records, staff schedules, policies and procedures, staff education records, observed medication administration, staff to resident interactions and care.

During the course of the inspection, the inspector(s) spoke with general manager, director of care (DOC), associate director of care (ADOC), food service manager (FSM), director of recreation, environmental service manager (ESM), manager of clinical informatics, social worker, registered dietitian, registered practical nurses (RPN), registered nurses (RN), family council president, resident council president, personal support workers (PSW), laundry aide, and residents, and family members of residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive annual training provided for in subsection 76 (7) of the Act in behaviour management.

A review of the staff training record and interviews with the manager of clinical informatics and the ADOC confirmed that 38% of direct care staff did not receive annual training in behaviour management, in 2014. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receive annual training provided for in subsection 76 (7) of the Act in behaviour management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On September 22, 2015, the inspector observed during medication administration for an identified resident, that the emptied individual resident medication packet was placed into a waste bin located at the side of the medication cart.

An interview with an identified registered staff revealed that the registered staff who administers medications will collect the opened and emptied medication packets at the end of the shift and place them in a bag, which is then removed to the waste disposal chute located on the identified unit.

An interview with the ADOC and the ESM reported that the waste is picked up three times a week by the garbage collection services landfill company. Further interview with the ADOC confirmed that an identified resident's personal health information was not fully protected and kept confidential according to the Act. [s. 3. (1) 11.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

On an identified date, the inspector observed while an identified resident was in bed, the two bed side rails were in a raised position.

A review of the current written plan of care revealed that the resident has physical limitations, and requires extensive two-person assist with activities of daily living.

An interview with the resident revealed that he/she prefers both bed side rails raised when he/she is in bed.

The written plan of care did not identify the need for bed side rails in a raised position when the identified resident is in bed.

An interview with an identified PSW indicated that whenever the resident is in bed, the two side rails are raised. An interview with an identified registered staff and the ADOC confirmed that the written plan of care did not identify the need for bed side rails when the resident is in bed, therefore not providing clear direction to staff regarding the use of bed side rails. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

An interview with an identified registered staff revealed that an identified resident does not like other residents to sit in front of him/her while facing him/her as that will trigger a responsive behaviour.

A record review revealed that an identified resident was diagnosed with specified health conditions. A review of identified progress notes, revealed that the resident does not like other residents to sit beside him/her, and he/she tells them he/she does not want to speak with them and that they should go away.

The current written plan of care does not identify the potential trigger of other residents sitting beside him/her or facing him/her, eliciting a responsive behaviour.

Interviews with an identified registered staff and the ADOC confirmed that the resident’s behavioural triggers, responsive behaviours and interventions were not identified in the written plan of care. [s. 26. (3) 5.]

2. Interviews with identified PSWs and registered staff revealed that an identified resident has responsive behaviours related to activities of daily living.

A record review of the minimum data set (MDS) quarterly review assessment of an identified date indicated that an identified resident has incidences of increased responsive behaviours. The assessment indicated that the resident assessment protocol (RAP) indicated that the resident had increased responsive behaviours, and would be care planned. A review of the resident's current written care plan did not include a section for the specified responsive behaviours based on the MDS assessment.

An interview with the ADOC confirmed that an identified resident's increased responsive behaviours to care was not included in the written plan of care. [s. 26. (3) 5.]

Issued on this 14th day of October, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.