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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 1, 2019	2019_650565_0003	009959-17, 013743-17, 014390-17, 014701-17, 016940-17, 022855-17, 024105-17, 024515-17, 026521-17, 028011-17, 028523-18	Critical Incident System

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

MATTHEW CHIU (565), ANGIEM KING (644), JUDITH HART (513), SLAVICA VUCKO (210)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 1, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 19, and 20, 2019.

During the course of the inspection, the Follow-Up intake log #028523-18 related to accommodation services – housekeeping program was inspected.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- #009959-17, #013743-17, 014390-17, #014701-17, #022855-17 related to prevention of abuse, and
- #024105-17, #024515-17, #026521-17, #028011-17 related to missing residents.

- During the course of the inspection, the Complaint intake log #016940-17 related to authorization for admission to the home was inspected.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Associate Director of Nursing (ADON), Neighbourhood Coordinator (NC), Director of Environmental Services (DES), Recreation Supervisor (RS), Registered Nurse (RN), Registered Practical Nurse (RPN), Program Therapist, Personal Support Worker (PSW), Recreation Aide (RA), Housekeeping Aide (HA), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 87. (2)	CO #001	2018_759502_0012	565

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.

For the purpose of the Act and the Ontario Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Review of the CIS reports revealed that on and identified date, resident #012 demonstrated a specified physical action towards resident #013. As a result, resident #013 sustained an identified injury a few days later.

Records review revealed residents #012 and #013 both had cognitive and physical impairments at the time of the incident. Resident #012 had history of demonstrating the identified responsive behaviours towards other residents. Resident #012 was assessed, and strategies were in place. The records further stated on the identified date and time, RA #111 reported to RN #108 that resident #012 demonstrated the specified physical action towards resident #013 in an identified common area of the home. As a result, resident #013 sustained the identified injuries.

Interview with RA #111 indicated on the identified date and time in the identified common area of the home, they saw residents #012 and #013 sitting next to each other and resident #012 demonstrated the specified physical action towards resident #013. The staff member intervened, removed resident #013 from the area, and reported the incident to RN #108 and ADON #113 on the floor. RA #111 further described that resident #013 was in distress and sustained the identified injuries as a result of the incident.

Interview with RN #108 indicated RA #111 had reported the incident to them on the identified date, and resident #013 sustained the injuries as above mentioned. RN #108 further stated that resident #013 was in distress after the incident and said resident #012 demonstrated the specified physical action towards them. RN #108 indicated they thought that it was physical abuse towards resident #013.

Interview with ADON #113 and the GM indicated that the above mentioned incident between resident #012 and #013 had happened, and resident #013 sustained the injuries as a result of the physical action by resident #012. The staff acknowledged that the home has failed to protect resident #013 from physical abuse by resident #012. [s. 19. (1)]

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 residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred should immediately report the suspicion and the information upon which it was based to the Director.

A review of a CIS report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date indicated the alleged abuse had occurred on the day before it was reported. The RS was walking along the identified home area, and they heard and observed the specified interactions between resident #021 and two team members.

Record review indicated the home initiated their investigation about the suspicion of emotional abuse when it was reported by the RS on the same day the incident happened. Further review indicated that the allegation of abuse had not been reported to the Director until the identified date and time the next day.

During an interview, the RS indicated that they suspected abuse as they had heard and observed the identified interactions between PSWs #102, #103 and resident #021. The RS reported the incident to the GM on the same day.

During an interview, the GM acknowledged that the allegation of abuse had been reported on the same day to the leadership team, and it should have been reported to the Director immediately. [s. 24. (1)]

2. Review of two CIS reports revealed that on an identified date, resident #012 demonstrated a specified physical action towards resident #013. As a result, resident #013 sustained an identified injury a few days later. The CIS reports further revealed that the incident was first reported to the MOHLTC four days after it happened.

Interview with RA #111 indicated on the identified date and time in an identified common area of the home, they saw residents #012 and #013 sitting next to each other and resident #012 demonstrated the specified physical action towards resident #013. The staff member intervened, removed resident #013 from the area, and reported the incident to RN #108 and ADON #113 on the floor. RA #111 further described that resident #013 was in distress and sustained the identified injuries as a result of the incident.

Interview with RN #108 indicated RA #111 had reported the incident to them on the identified date, and resident #013 sustained the injuries as above mentioned. RN #108 further stated that resident #013 was in distress after the incident and said resident #012 demonstrated the specified physical action towards them. RN #108 indicated they thought that it was a physical abuse towards resident #013, and they did not recall if they reported it to the manager on duty that day.

Interview with ADON #113 indicated they recalled the above mentioned incident between residents #012 and #013, and they were the management staff on duty that day. ADON #113 further stated that they were unaware of resident #013's identified injuries until four days later, the day that ADON #113 first reported the incident to the MOHLTC.

Interview with the GM indicated that if there was management staff on duty in the

building, the staff who discovered an abuse of a resident should report it to the charge nurse or the management staff. The management staff should be responsible for reporting it to the MOHLTC using the after hours number or the CIS. The GM confirmed that the above mentioned incident should have been reported to MOHLTC immediately, but it was not reported until four days later. [s. 24. (1)]

3. Review of a CIS report revealed that on an identified date, resident #017 witnessed a staff member demonstrating a specified physical action towards resident #015. The home started the investigation on the same day, and the CIS report was first submitted to the MOHLTC three days after the incident happened.

Record review revealed that on the identified date, resident #017 reported to RPN #116 that they witnessed a staff from an identified shift demonstrated a specified physical action towards resident #015.

Interview with resident #017 indicated they had no recollection of the incident.

Interview with RPN #116 indicated resident #017 reported the above mentioned incident to them on the same day, and they suspected that abuse had occurred. RPN #116 stated that they reported it to the manager on duty that day.

Interview with DES #106 indicated that they were the manager on duty on the day of the incident, and it was reported to them the same day. DES #106 further stated that they notified the GM that day, and DES #106 had not reported the incident to the MOHLTC.

Interview with the GM indicated when DES #106 reported to them, they directed DES #106 to initiate an investigation. The GM confirmed that the incident should have been reported to the MOHLTC immediately on the identified date, but it was not reported until three days later. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident has occurred should immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 15th day of March, 2019

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

Original report signed by the inspector.