Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux 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
Dec 16, 2019	2019_650565_0022	013304-19, 019483-19	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), NAZILA AFGHANI (764)

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): November 19, 20, 21, 22, 25, 26, and 27, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- #013304-19 related to prevention of abuse, and
- #019483-19 related to missing resident.

During the course of the inspection, the finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) related to resident #004 was issued under concurrent Complaint inspection #2019_816722_0023.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Director of Nursing Care (ADNC), Associate Directors of Nursing Care (ADNC), Neighbourhood Coordinators (NC), Director of Recreation (DOR), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Housekeeper, 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:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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)**

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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others who provide direct care to resident #004 were kept aware of the contents of the resident's plan of care.

Review of the CIS report revealed that on an identified date, resident #004 informed staff that they would like to go for a specified activity. An identified incident happened to the resident and the home responded to the incident in a specified manner.

Record review revealed resident #004 had identified medical diagnoses. Their plan of care stated, at the time of the above-mentioned incident, a specified care set out for the above-mentioned activity.

Review of resident #004's progress notes indicated that on the identified date and time, the resident went for the activity and the above-mentioned incident happened. The home responded in a specified manner, and the resident had not sustained any injuries as a result of the incident.

Interview with RN #116 indicated that on the identified date and time, resident #004 told the RN that they wanted to go for the activity. RN #116 stated they did not realize that resident #004 had the specified care set out for the specified activity and assisted the resident, in a specified manner, without giving them the specified care.

Interviews with NC #115 and the GM indicated that the care set out for the specified activity was part of the resident's plan of care. The GM stated that, before allowing resident #004 to go for the specified activity, RN #116 should have reviewed the specified care. The GM acknowledged the home failed to ensure that RN #116 was kept aware of the contents of resident #004's plan of care related to their specified activity. [s.

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 the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #003 demonstrating responsive behaviours, actions including assessments and reassessments were taken to respond to the needs of the resident.

Review of two CIS reports revealed that on an identified date, resident #002 had a fall and sustained a significant injury. Resident #002 complained about a specified interaction with resident #003 before they fell.

Review of resident #003's RAI-MDS assessment revealed that resident #003 had cognitive and physical impairments.

Record review of an identified seven-month period revealed resident #003 had demonstrated identified responsive behaviours on five identified dates. The resident did not receive any assessment or reassessment related to their responsive behaviors.

Interviews with PSWs #105, #109, #110, and #112 indicated that resident #003 had demonstrated the identified responsive behaviours. PSW #112 further mentioned they sometimes called the nurse to manage the resident's behaviours in order to ensure the safety of staff and co-residents.

Interview with RN #111 indicated that when a resident demonstrates the identified responsive behaviours, they will initiate the Dementia Observation System (DOS) to monitor the resident, and send a referral to the Personal Expressions Resource Team (PERT) lead for assessment. When reviewing resident #003's records with RN #111, the RN stated no referral, assessment, or re-assessment was completed for resident #003's responsive behaviours.

Interview with ADOC #103, who was the PERT lead, stated that for any resident demonstrating responsive behaviours, the team should send them a referral for assessment. ADOC #103 would assess the resident's responsive behaviours and collaborate with the team to develop interventions to manage their behaviours. ADOC #103 stated there was no referral for resident #003's responsive behaviours and confirmed that no assessment or reassessment was completed for resident #003's responsive behaviours as required. [s. 53. (4) (c)]

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 for each resident demonstrating responsive behaviours, actions including assessments and reassessments are taken to respond to the needs of the resident, to be implemented voluntarily.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.