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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 8, 2022
Inspection Number [2022_1219_0001]
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
Fairview Nursing Home, Toronto

Lead Inspector
Adelfa Robles (723)

Inspector Digital Signature
Adelfa P Robles
2022.07.08 08:58:56 -04'00'

Additional Inspector(s)
Julie Ann Hing (649) was also present as an assessing mentor during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 22, 23, 24, 28, and 29, 2022.

The following intake(s) were inspected:

- Intake #013462-21, related to an unwitnessed fall.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services

INSPECTION RESULTS

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home has an infection and prevention and control lead whose primary responsibility is the home's infection prevention and control program.

Rationale and Summary

Assistant Director of Nursing Care (ADNC) stated that Infection Prevention and Control (IPAC) Lead role was shared by the General Manager (GM), Director of Nursing Care (DNC), ADNC and the Environmental Manager. DNC stated they were doing both the DNC and IPAC Lead roles since May 2021.

There was low risk from not having an IPAC Lead whose primary responsibility was to lead the home's infection control since the home shared the responsibility to members of the leadership team.

Sources:
Schlegel Villages Temporary Employment Contract DNC at Fairview Nursing Home and staff interviews.

[723]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to carry out every operational or policy directive issued by the Minister that applied to the term care home.

Rationale and Summary

The Minister's Directive titled "Covid-19 Long Term Care Homes" required that the home conduct regular IPAC self audits at a minimum of every two weeks when the home was not in outbreak and every week during an outbreak. At minimum, the home's self audit must include Public Health Ontario (PHO)'s Covid-19 Self Assessment Audit Tool for Long Term Care Homes and Retirement Homes.

Inspector #723 was provided with the home's completed IPAC Self Audits from April to June 2022. The home did not complete an IPAC Self Audit Assessment at the minimum required frequency for the month of May 2022.

There was low risk when the home missed to complete PHO Self-Assessment Audit at the minimum required frequency because the home still conducted regular IPAC audits using their own tool.

Sources:
Minister's Directive: Covid-19 response measures for long term care homes, published April 27, 2022, Covid-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units Version 7 - June 27, 2022, PHO's COVID-19: Self-Assessment Audit Tool for LTCHs and RHs published December 23, 2021, the home's IPAC self-audit records and staff interviews.

[723]

WRITTEN NOTIFICATION DINING AND SNACK SERVICE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 79 (1) 9

The licensee has failed to ensure that a resident was provided with proper techniques to assist with eating including safe positioning.

Rationale and Summary

Personal Support Worker (PSW) provided feeding assistance to a resident with force using a large size spoon. The resident was in a tilted position. This practice was observed several times by the inspector during the meal service.

DNC stated that residents should be fed upright using a small spoon.

Failure to apply safe feeding techniques when assisting a resident with feeding placed the resident at an increased risk for chocking and negative health outcomes

Sources:
June 22, 2022, Dining Observation, Schlegel Villages Food Services Manual Tab 08-01 and staff interviews.

[723]

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WRITTEN NOTIFICATION SAFE STORAGE OF DRUGS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rationale and Summary

A medication cart was observed by inspector #649 to be unattended, unlocked with the keys inserted into the keyhole. The Registered Practical Nurse (RPN) was inside a resident room at that time.

ADNC and DNC both stated that medication carts should be kept always locked when not in use.

Leaving the medication cart unlocked and unattended increased the risk of unauthorized access to the drugs, which included narcotics.

Sources:
June 22, 2022, observation and staff interviews.

[723]