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

Toronto Service Area Office
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Original Public Report

Report Issue Date August 24, 2022
Inspection Number 2022_1219_0002
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)

Additional Inspector(s)
April Chan (704759)
Fiona Wong (740849)

Inspector Digital Signature
Adelfa P Robles
2022.08.25 11:47:11 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 8, 9, 10, 11, 15, 16 and 17, 2022, onsite; August 12, 2022, offsite.

The following intake(s) were inspected:

- Log #012092-21 (Critical Incident System (CIS) # 2723-000008-21) related to injury of unknown cause
- Log #010874-21 (CIS # 2723-000007-21) related to a fall
- Log #005810-22 (CIS # 2723-000005-21) related to improper care
- Log #012349-22 (Complaint) related to multiple care concerns
- Log #009882-22 (Complaint) related to pest control

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect

- Reporting and Complaints
- Resident Care and Support Services
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that mobility plan of care was revised when the use of a wheelchair was no longer necessary for a resident.

Rationale and Summary
A resident was to be provided with a wheelchair for mobility in a specified situation.

During inspection, the resident was observed ambulating independently with a walker. A wheelchair for mobility was not provided to the resident routinely and the registered staff acknowledged that the mobility plan of care required revision.

The mobility plan of care was revised to include that a wheelchair would be used for mobility if the resident was in pain or was weak.

Sources: observations of the resident, resident's clinical records and staff interviews.

Date Remedy Implemented: August 16, 2022

[704759]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident care needs changed, related to the use of prescribed device.

Rationale and Summary:

A resident was observed using an unprescribed device during the inspection. Resident's clinical records as signed off by the registered staff from April to August 2022, showed the resident was to use the prescribed device at all times.

Staff stated that the resident no longer required the prescribed device. Registered staff and the Director of Nursing Care (DNC) stated that the prescribed device was discontinued in June 2022.

The prescribed device was discontinued in the resident's clinical record.

Sources: resident observations, clinical records and staff interviews.

Date Remedy Implemented: August 9, 2022

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NC#03 remedied pursuant to FLTCA, 2021, s. 154(2)

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that additional precautions were followed in the IPAC program.

The licensee failed to implement measures in accordance with the IPAC Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, the IPAC lead failed to place Point of Care signage indicating that enhanced IPAC control measures were in place as required by Additional Requirement 9.1 under the Standard.

Rationale and Summary:

A resident bedroom was observed with Contact Precaution signage posted outside of their door.

IPAC Lead and registered staff stated that the home had no residents on additional IPAC precautions.

Contact Precaution signage was immediately removed from the resident's bedroom door.

Sources: observations in the home area, resident clinical records, IPAC Standard for Long Term Care Homes, April 2022, and staff interviews.

Date Remedy Implemented: August 8, 2022

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WRITTEN NOTIFICATION PLAN OF CARE

NC#01 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 the plan of care was provided to resident as specified in the plan.

Rationale and Summary

The home submitted a CIS when a resident sustained an injury and was transferred to hospital for further treatment.

Resident required a specified positioning device when sitting on their wheelchair. Resident was observed on several occasions without the required device when on their chair. Staff stated they did not apply the specified positioning device when the resident was on their chair. Kinesiologists stated that the positioning device was indicated to promote healing. Registered staff and DNC stated that staff were expected to follow resident plan of care as specified in the plan.

By not following the resident's plan of care there was a risk of delayed healing.

Sources: resident's observations, clinical records, and staff interview.

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WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: LTCHA, 2007, s. 6 (10) (c)

The licensee has failed to ensure a resident was reassessed and the plan of care was reviewed and revised when the care set out in the plan had not been effective after the resident sustained multiple falls.

Rationale and Summary

The resident was at risk for fall due to unsteady gait and cognitive impairment. The resident had three fall incidents over a two-month period.

The resident's written plan of care was not reviewed and revised after they sustained multiple falls. The home's Fall Prevention and Management Program indicated that registered nursing team member may refer to physician, physiotherapist/kinesiologist/exercise therapist if a resident had two or more falls.

Staff, Kinesiologist and DNC confirmed that the care plan should have been reviewed and revised after the falls. The Kinesiologist further stated that referrals should have been sent to Program and Active Living (PAL) services considering the multiple falls.

The resident was at risk for subsequent falls and injury when they were not referred to PAL and plan of care was not reviewed and revised.

Sources: CIS #2723-000007-21, resident's clinical records, Schlegel Villages Fall Prevention and Management Program [LTC] (Tab 06-02) and staff interviews.

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WRITTEN NOTIFICATION INFORMATION FOR RESIDENTS, ETC

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

Non-compliance with: FLTCA, 2021, s. 84 (1) (a)

The licensee has failed to ensure that a package of information was given to every resident and to the Substitute Decision Maker (SDM) of the resident, at the time that a resident was admitted to the home.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC), when a resident's SDM did not receive the resident information package including the Resident's Bill of Rights and other care concerns.

Complaint response submitted by the home to the MLTC and to the SDM indicated that it was missed at the time of admission. This was confirmed by the home's General Manager (GM).

Failure of the home to provide the resident information package, caused lack of awareness for the resident's SDM, of relevant information, support and services offered in the home.

Sources: complaint records, interviews with the GM and resident's SDM.

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WRITTEN NOTIFICATION INFORMATION FOR RESIDENTS, ETC

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

Non-compliance with: FLTCA, 2021, s. 84 (1) (e)

The licensee has failed to ensure that the contents of the admission information package and revisions were explained to the person receiving them.

Rationale and Summary

A revised Schlegel Villages Resident Handbook was provided to a resident's SDM, including additional information and updates as per the requirements under Fixing Long-Term Care Act (FLTCA) 2021. The DNC and the GM acknowledged that the revised resident information package was not explained to resident's SDM as required.

Failure of the home to explain the details of the revised resident information package caused no harm to the resident.

Sources: resident's complaint records, Schlegel Villages Long Term Care Resident Handbook and interviews with DNC and GM.

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WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49 (1)

The licensee has failed to ensure that a resident was assessed on each shift for 24-hours post fall as required by the home's policy.

In accordance with O. Reg 246/22 s. 8 (1) (b), the licensee is required to ensure that there are strategies to reduce or mitigate falls, including the monitoring of residents and must be complied with.

Specifically, staff did not comply with the policy that "resident will be assessed each shift for 24-hours after the fall and a progress note will be completed x three shifts" of the home's Falls Prevention and Management Program.

Rationale and Summary

A complaint was received by the MLTC, regarding a resident's fall on a specified date.

The resident was not assessed each shift for 24-hours after they had a fall. Registered staff stated that an assessment was missed during the night shift. DNC stated that staff were expected to monitor resident for 24-hours after a fall incident and document in the progress notes.

Failure of the staff to follow the home's policy on post fall management presented minimal risk to the resident as the resident was still monitored in other shifts 24-hours post fall.

Sources: resident's clinical records, Schlegel Villages Fall Prevention and Management Program [LTC] (Tab 06-02) and staff interviews.

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WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 49 (1)

The licensee has failed to comply with the falls prevention and management program to manage a post-fall incident for a resident.

In accordance with O. Reg 79/10 s. 8 (1) (b), the licensee is required to ensure that the registered nurse starts the head injury routine immediately in the event of an unwitnessed fall and referral to physiotherapist or kinesiologist may be done when there is a change in weight bearing status or unresolved pain and must be complied with.

Specifically, staff did not comply with the policy "Fall Prevention and Management Program" Tab 06-02, which was captured in the licensee's falls prevention and management program.

Rationale and Summary

A resident had a fall and experienced pain. Staff did not comply with the home's policy and procedure for the resident after this fall. Specifically:

- Head Injury Routine was not initiated; and
- Physiotherapist or Kinesiologist referrals were not submitted until after a week

Two days after the fall, the resident was identified with an injury and required a new mobility device for ambulation. Both the Kinesiologist and Assistant Director of Nursing Care (ADNC) identified that staff should have submitted physiotherapist or kinesiologist referrals earlier and without delay.

There was no significant impact identified to the resident when staff did not comply with the home's policy and procedures for fall prevention and management.

Sources: Schlegel Villages Fall Prevention and Management Program [LTC] (Tab 06-02), resident's clinical records, home's investigation notes and staff interviews.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (7) (11)

The licensee has failed to ensure residents were supported to perform hand hygiene prior to receiving meals and during meals when their hands were soiled.

The licensee failed to implement measures in accordance with the IPAC Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, the IPAC lead failed to implement a hand hygiene program that ensure residents are supported to perform hand hygiene prior to receive meals and snacks as required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary

The home's hand hygiene policy indicated that team members should encourage resident hand hygiene practices and to offer opportunities for hand hygiene around meals and snack times. IPAC Lead indicated that hand hygiene such as the use of hand sanitizers should be offered to residents prior to meals.

A meal observation in a home area was completed during the inspection. Residents were not observed to be assisted with hand hygiene prior to lunch meal.

A resident was provided with meal tray service and indicated that assistance to clean their hands was not offered prior to the meal, and that assistance for hand hygiene prior to meals was not regularly offered.

Another resident was observed picking up items on the floor and continuing with their meal. Registered staff assisted the resident but did not support them with hand hygiene. Registered staff acknowledged that hand hygiene for resident should have been offered. The resident also indicated that they did not receive assistance with cleaning their hands before their meal.

There was a risk of harm when residents were not offered hand hygiene prior to and during meals when hands get soiled.

Sources: August 8, 2022, observations in the home, Schlegel Villages Hand Hygiene Program (Tab 06-13), IPAC Standard for Long Term Care Homes April 2022, interviews with residents and staff.

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WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 109 (1)

The licensee has failed to ensure that a written complaint that alleged harm or risk of harm, including but not limited to, physical harm, to one or more residents was immediately forwarded to the Director.

Rationale and Summary

The home received a written complaint, regarding several care concerns including allegation of emotional abuse to a resident. The home's policy required that every written complaint regarding care of a resident or the operation of the long-term care home shall be immediately forwarded to the Director along with the documented record for the complaint.

The Director was informed about the details of the complaint along with the home's response 10 business days after the complaint was received by the home as confirmed by the GM.

There was a low risk when the home failed to inform the Director immediately of the written complaint since the allegation was unsubstantiated based on the home's completed investigation.

Sources: Schlegel Villages Resident/Family Complaints [LTC & RH] (Tab 11-21), home's complaint records and interview with the GM.

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WRITTEN NOTIFICATION OBTAINING AND KEEPING DRUGS

NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 131 (2)

The licensee failed to ensure that pain medication was administered to a resident in accordance with the directions for use as specified by the prescriber.

Rationale and Summary

A resident was prescribed as needed (PRN) pain medication every four hours. The resident was observed to be in pain. Pain assessment was completed with score of six out of ten but there was no pain medication administered. The resident was reassessed four and a half hours later and continued to experience pain and had difficulty weight bearing.

Registered staff and DNC stated that pain medication should have been administered when the resident was experiencing pain.

There was an impact to a resident when pain medication was not administered, leaving them in pain and discomfort.

Sources: CIS #2723-000007-21, resident's clinical records, Schlegel Villages Pain Management Program (Tab 04-48) and interviews with staff.

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