Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: January 19, 2023	
Inspection Number: 2022-1219-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Fairview Nursing Home, Toronto	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature** Maya Kuzmin Digitally signed by Maya Kuzmin Date: 2023.01.19 14:01:12 -05'00'
Additional Inspector(s) Oraldeen Brown (698)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
Dec 7-9 and 13, 15-16, 2022.

The following Critical Incident intake(s) were inspected:

- Intake: #00003141 was related to resident to resident physical abuse
- Intake: #00012013 was related to unexpected death of a resident
- Intake: #00013025 was related to resident to resident physical abuse
- Intake: #00013896 was related to improper transferring of resident resulting in injury
- Intake: #00014702 - anonymous complainant was related to alleged staff to resident physical abuse

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

Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the infection prevention and control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead did not ensure that the hand hygiene program included 70-90% alcohol-based hand rub as is required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

Observations during the initial tour, revealed that there were four bottles of expired alcohol based hand rubs (ABHRs) on tables in the dining rooms, located on an identified floor in the dining room in the long term care home. IPAC lead #102 acknowledged that expired ABHRs should not be on the units. Fifteen minutes later IPAC lead #102 communicated to the inspector that the expired hand sanitizers were discarded.

At a later date, the inspector observed one expired ABHR on an identified floor in the dining room which was shown to the IPAC lead; the IPAC lead discarded it. On that same date, Environmental Director #117 sent the inspector an email showing that an order for hand sanitizers (with expiry date of September 2025) was placed.

Sources: ABHR order email; observations; and interviews with IPAC lead #102 and Environmental lead #117.

[741674]

Date Remedy Implemented: December 13, 2022

WRITTEN NOTIFICATION: Plan of Care

NC ##002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

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The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of a resident's lab results so that their assessments were integrated and were consistent with and complement each other.

Rationale and Summary:

A Critical Incident (CI) was submitted to the Director on an identified date, related to an unexpected resident death.

The registered staff who received the resident's verbal report from the lab on an identified date, did not communicate the results with the home, or doctor on call.

Failure to communicate critical lab results to the doctor put the resident at risk for unaddressed health complications.

Sources: Home's investigation notes; Resident's lab results and progress notes; interview with DOC #101 and other staff.

[698]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (a)

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The licensee has failed to ensure that any surveillance protocols related to Rapid Antigen Tests (RAT) issued by the Director for a particular communicable disease or disease of public health significance were complied with regarding proper use of COVID-19 testing kits.

Rationale and Summary:
Observations of the home's Infection Prevention and Control (IPAC) practices related to Rapid

Antigen Testing (RAT) identified that Personal Support Worker (PSW) #107 did not follow the manufacturer's instructions of the RAT testing device on an identified date. The Inspector observed staff #107 administer the RAT test on a general visitor. RAT results were provided to the visitor within approximately three minutes, then they were permitted entry into the Long-Term Care Home (LTCH). PSW #107 stated that they were expected to wait fifteen minutes after completing the RAT test before providing results to the visitor, and permitting entry into the LTCH. IPAC lead #102 acknowledged that staff who conducted RAT testing are to follow the manufacturer's instructions, which specifies that results should be read fifteen minutes after testing.

Due to the home not following the RAT device instructions, there was a risk of harm to residents, staff and visitors related to the spread of infectious disease.

Sources: Abbott Panbio COVID-19 Ag Rapid Test Device (NASAL); observations; and interviews with Personal Support Worker #107 and the IPAC lead.

[741674]

WRITTEN NOTIFICATION: Transferring and Positioning

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

Rationale and Summary:
The resident experienced a fall from a mechanical lift during a transfer by PSWs #118 and #119 and sustained injuries to identified body regions. This same resident was sent on two occasions to a trauma center, for excessive bleeding. The PSWs did not properly secure the mobility accessory to the mechanical lift during transfer, and the resident fell to the floor.

Sources: Critical Incident report; resident's clinical records; interview with DOC #101 and other staff.

[698]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (2)

The licensee has failed to ensure that the Director was immediately informed of resident #001's unexpected death in the hospital and of resident #004's critical incident.

Rationale and Summary:

(i) Resident #001 experienced respiratory distress, was sent to hospital, and passed away. The incident was reported to the Director three days later.

Sources: CIS report; resident #001's progress notes; and interview with DOC #101.

[698]

(ii) Resident #004 experienced a fall and was sent to hospital. X-ray results indicated that the resident sustained a fracture on an identified body region. The incident was reported to the Director seven days later.

Sources: CIS report; resident #004's clinical records; interviews with DOC #101 and other staff.

[698]