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

Amended Public Report (A1)

Report Issue Date December 2, 2022
Inspection Number 2022_1219_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 Kitchener ON N2E 4H5

Long-Term Care Home and City
Fairview Nursing Home
14 Cross Street Toronto ON M6J 1S8

Inspector who Amended
Nicole Ranger (189)

Inspector who Amended Digital Signature
Nicole S Ranger
Digitally signed by Nicole S Ranger
Date: 2023.01.23 15:24:28 -05'00'

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to correct and add log # to the Inspection Summary in the report.

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 29, 30, October 4, 5, 6, 7, 2022 on-site; October 13, 19, 2022 – off-site.

The following intake(s) were inspected:

- Log # 00005571 (CIS #2723-000015-22, CIS #2723-000016-22) related to injury of a resident.
- Log # 00003466 (CIS #2723-000009-21) related to unknown injury of resident.
- Log # 00006682 (Complaint) related to injury of a resident (associated with Log #00005571).

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

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

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)

Non compliance with: FLTCA, 2021 s. 5

The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

On October 5, 2022, the inspector conducted a tour of an identified unit and observed a wheeled cart in the hallway with cleaning tools left unattended. Housekeeper #123 arrived on the unit and placed the wheeled cart containing the tools inside the resident room they were working in, and acknowledged the cart should not have been left unattended.

On October 5, 2022, the inspector observed on identified unit electrical room door open with contractor tools left unattended. The Administrator immediately moved the tools and acknowledged that contractor tools and equipment should not have been left unattended.

The Administrator reported that a discussion was held with the contractors and housekeeping staff to ensure the safety of the residents.

Date Remedy Implemented: October 5, 2022 (189)

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that the resident was reassessed, and the plan of care reviewed and revised when resident #002 care needs changed.

Rationale and Summary:

The home submitted a Critical Incident System (CIS) report when resident #002 sustained an injury and was transferred to hospital for further treatment.

On an identified date, resident #002 complained of pain to an identified area and received pain medication that day. The resident was assessed by the physician and orders for x-ray of the area was recorded. The resident received the x-ray 7 days later, which revealed an injury. The resident was sent to hospital and treatment applied.

PSWs #102, #103, and #104 stated that during a period of time, resident #002 complained of pain, and they reported this concern to RPN #101. RPN# 101 confirmed that they did receive this information from the PSWs but did not reassess the resident's pain further; however, they made a notation in the Physician (MD) book for reassessment. The resident was assessed by the MD and ordered for an x-ray to be completed. The x-ray was not completed until 7 days later. According to RPN # 101 and ADOC #100, the usual length of time for an x-ray to be conducted was between two to four days.

The Acting Director of Care (A/DOC) acknowledged that a pain assessment and diagnostic test were not completed in a timely manner, and that resident #002 was not reassessed nor the plan of care revised when their care needs changed.

Failure to reassess the resident's pain and timely completion of the x-ray placed resident #002 at risk of change of status.

Sources: Progress notes, care plan, interviews with PSW # 102, #103, #104, RPN #101, A/DOC #106 and other staff.

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COMPLIANCE ORDER CO#001 TRANSFERRING AND POSITIONING TECHNIQUES

NC#003 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 40

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg 246/22 s.40

The licensee shall:

1. Conduct random audits on day and evening shifts for three weeks to ensure that all staff who perform resident transfers use safe transferring and positioning techniques when providing care to residents.
2. Maintain records of requirements #1 including but not limited to who completed the audits, date of the audits, outcome, and actions taken as a result of any deficiencies identified.

Grounds

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 a resident.

On an identified date, Personal Support Worker (PSW) #105 noticed swelling to an identified area of resident #001's body and called RPN #112 to assess. The resident was not able to express pain but was holding and guarding the area. RPN #112 assessed the resident's injury and transferred them to hospital on the same day. The resident was diagnosed with an injury, underwent surgery and passed away a few days later.

Record review and staff interviews identified the following events:

- On an identified date, PSW# 105 stated they were assigned to resident #001. Resident #001 was transferred twice on that day; from bed to wheelchair, and back from wheelchair to bed using a hoyer lift, by PSW # 105, Housekeeper #113 and Housekeeper #111.
- PSW # 105 reported that after the second transfer, they noticed swelling to an identified area and called the nurse to assess.
- RPN #112 stated that when they entered the room, they observed an identified body area to resident #001 was swollen.
- Exercise Therapist #115 and A/DOC #106 stated that when they entered the room and observed the resident, the identified body area was swollen and the A/ DOC #106 directed the staff to transfer the resident to the hospital.
- Resident #001 was transferred to hospital and diagnosed with an injury. The resident underwent surgery and passed away a few days later.
- PSW #116 reported that on an identified date, they received two calls from PSW #105, asking them to tell the home's management that they assisted with the transfer. PSW #116 told PSW #105 that they did not assist with the transfer and refused to tell the management that they did.

- PSWs #103, #116 and #117, who also worked on the second floor, stated that when they required assistance with transferring a resident using the mechanical lift, they would ask another PSW instead of a housekeeper.
- Administrator #118 and A/DOC #106 informed the inspector that during the home's investigation, they believed PSW #105 transferred the resident alone.

Throughout the staff interviews and review of the home's investigation notes, the inspector confirmed that PSW #105 requested PSW #116 to lie and say that they assisted with the resident's transfer on an identified date. It was reported to the inspector by all PSW staff interviewed that the usual practice is to request assistance for mechanical lift transfer of residents from another PSW staff; and reserving housekeepers as a last resort. RPN #112 reported that upon observation of the resident, it appeared the identified area was swollen and injured. Administrator #118 reported the home believed that PSW #105 transferred resident # 001 alone without assistance. Coroner #122 reported that the type of injury sustained by the resident to the identified area, typically occurs during a fall, or with some force applied.

Given what staff told the inspector about what they observed, what was discussed amongst staff, what occurred, the degree of injury to the resident, and the resident's listed cause of death, the inspector concluded that staff failed to use safe transferring techniques when assisting resident # 001.

Failure to ensure that staff used safe transferring technique placed resident #001 at risk of injury.

Sources: Resident #001's written plan of care, progress notes, home's investigation notes, complaint log #017001-22, CIS report #2723-000015-22, CIS report #2723-0000016-22, interviews with PSW #103, PSW # 105, PSW #116, PSW #117, PSW # 119, PSW #120, Housekeeper #111, Housekeeper #113, Exercise Therapist # 115, Director of Environmental Services #121, RPN #112, A/DOC #106, Administrator #118 and Coroner #122.

[189]

This order must be complied with by January 13, 2023

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REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.