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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: September 29, 2023	
Inspection Number: 2023-1219-0006	
Inspection Type: Proactive Compliance Inspection	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Fairview Nursing Home, Toronto	
Lead Inspector Ryan Randhawa (741073)	**Inspector Digital Signature** Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2023.10.03 13:27:39 -04'00'
Additional Inspector(s) Reji Sivamangalam (739633)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6 - 8, 11 - 14, 18, 2023

The following intake(s) were inspected:

- Intake: #00095903 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices

Pain Management
Falls 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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's written plan of care was revised when a treatment was discontinued.

Rationale and Summary

A resident was receiving a treatment which was discontinued by the physician. The resident's written plan of care still included treatment.

A Personal Support Worker (PSW) verified that the resident no longer received the treatment.

Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator confirmed that the treatment was discontinued as per physician's order, but the written plan of care was not updated.

The Director of Care (DOC) acknowledged that staff were expected to update the written plan of care when the care set out in the plan was no longer necessary.

The resident's plan of care was updated when notified.

There was low risk to the resident when the plan of care was not revised.

Sources: Resident's clinical records written plan of care, interviews with PSW, RAI-MDS Coordinator and the DOC.

Date Remedy Implemented: September 13, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 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 a resident was provided with their diet texture and fall prevention interventions were provided to another resident as specified in their plan of care.

Rationale and Summary

1. A resident's written nutritional plan of care specified that the resident required a specific diet texture. During observations, the resident was provided with a meal which was not their diet texture.

A Registered Nurse (RN) verified that the resident was provided with a different diet texture and was required to have their specific diet texture according to the written plan of care.

The Registered Dietitian (RD) confirmed that the resident required the diet texture according to the written plan of care.

The DOC acknowledged that the staff were required to follow the plan of care when providing meals to residents.

There was a risk to the resident with chewing and swallowing when they were provided with the incorrect texture.

Sources: Observations, resident's written plan of care, interviews with RN, RD and the DOC. [739633]

Rationale and Summary

2. A resident required fall prevention strategies. During observations, the resident's fall interventions were not in place.

A PSW verified that the fall prevention interventions were not in place for the resident according to the written plan of care. The home's fall prevention Lead confirmed that the resident required the fall interventions in place as part of the resident's fall prevention strategies.

The DOC confirmed that the staff members were expected to follow the plan of care.

The resident was at increased risk of falls and injuries when the fall prevention strategies were not in place.

Sources: Observations, resident's clinical records, interviews with PSW, fall prevention Lead and the DOC.
[739633]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to the areas by residents, and the doors were kept closed and locked when they were not being supervised by staff.

Rationale and Summary:

On multiple days in September, it was observed that there were no staff supervising the doors leading to the following areas:

a. On the first floor resident home area, the storage room door was closed but unlocked despite there being a lock on the door.

b. On the second floor resident home area, the storage room, laundry chute room, and Material Safety Data Sheet (MSDS) room doors were closed but unlocked despite there being a lock on the doors.

c. On the third floor resident home area, the laundry chute room was closed but unlocked despite there being a lock on the door.

Staff indicated that the home’s storage room, laundry chute room, and MSDS room were non-residential

areas and each door leading to these rooms should have been kept closed and locked to restrict unsupervised access to those areas by residents. Staff acknowledged that the locks of these doors should have been in use and in working order.

Failure to ensure that the doors leading to non-residential areas were kept locked when they were not being supervised by staff put the residents at risk of exposure to hazardous material in the rooms and injury.

Sources: Observations on multiple days in September; interviews with PSWs, RN, and the DOC. [741073]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

The licensee has failed to ensure that the food was stored and served using methods to prevent food borne illness.

Rationale and Summary

During lunch, it was observed that the cold salad and dessert were not held in a refrigerated cold unit before being served to residents. The salad and dessert temperature was measured at 11 degrees Celsius and 21 degrees Celsius, respectively, before serving.

The home's Safe Food Handling Techniques Policy (Tab 09-37) stated that cold foods should be held in a refrigerated unit and kept at four degrees Celsius or less.

The Dietary Aide (DA) acknowledged that the salad and the desserts were not kept on a cold unit at the food serving station. The Director of Food Service (DFS) confirmed that cold foods must be held in a refrigerated cold unit before serving to residents in order to keep the temperature at the required range to prevent bacterial growth.

There was a risk of bacterial growth and foodborne illness to residents when cold foods were not stored and served without appropriate refrigeration.

Sources: Dining room observations, the home's Safe Food Handling Techniques Policy (Tab 09-37) and Food Temperature Control Policy (Tab 09-28), interviews with DA and DFS.
[739633]

WRITTEN NOTIFICATION: NUTRITIONAL CARE AND HYDRATION PROGRAMS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that food was served to residents at a safe temperature.

Rationale and Summary

The dessert was measured at 21 degrees Celsius before serving to the residents for lunch.

The home's Food Temperature Control Policy (Tab 09-28) stated that the danger zone temperature range was four degrees to 60 degrees Celsius and directed that the food temperature check must be conducted at the point of service. Prepared food should not be held or served at the danger zone temperature range for risk of bacterial growth. The home's Safe Food Handling Techniques Policy (Tab 09-37) stated that cold foods should be kept at four degrees Celsius or less.

The DA stated that the temperature of the dessert was not checked before serving to residents and should have been checked.

The DFS verified that food temperature checks must be done before serving to residents, and the dessert should not have been served to residents when the temperature was more than four degrees Celsius.

There was a risk of bacterial growth and food-borne infection to residents when the cold food was served to residents at an unsafe temperature.

Sources: Dining room observations, the home's Food Temperature Control Policy (Tab 09-28) and Safe Food Handling Techniques Policy (Tab 09-37), interviews with DA and DFS.
[739633]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that staff provided support for a resident to perform hand hygiene prior to receiving meals as required by Additional Requirement, specifically 10. 4 (h), under the Infection Prevention and Control (IPAC) standard.

Rationale and Summary

During observations, a resident was taken to the washroom during lunch, and staff did not provide hand hygiene assistance to the resident when they returned to the dining room and resumed eating.

A PSW verified that they did not provide hand hygiene assistance to the resident upon their return to the dining room.

A RN and the IPAC Lead both acknowledged that staff members should have provided hand hygiene assistance to the resident before they resumed eating.

Failure to support the resident with hand hygiene assistance increased the risk of infection transmission.

Sources: Observations, interviews with PSW, RN and IPAC lead.
[739633]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the IPAC program when the student Registered Practical Nurse (RPN) did not disinfect the vitals equipment after use.

Rationale and Summary

During observations, the student nurse had not disinfected the vitals apparatus after using it with a

resident who was ill and on additional precautions. They took it to the nursing station, and the RN disinfected the apparatus at the nursing station.

The student nurse verified that they did not disinfect the vitals apparatus after using it. The RN and IPAC Lead both confirmed that the apparatus should be disinfected immediately after use and before the staff left the resident's room.

There was a risk of transmission of infection when the apparatus was not disinfected immediately after use.

Sources: Observations, the home's policy Routine Practices (Tab 02-06) and interviews with student RPN, RN and IPAC Lead.
[739633]