Ontario

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

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

Toronto District
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Original Public Report

Report Issue Date: February 26, 2024	
Inspection Number: 2024-1219-0001	
Inspection Type: Critical Incident	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Fairview Nursing Home, Toronto	
Lead Inspector Maya Kuzmin (741674)	**Inspector Digital Signature**
Additional Inspector(s) JulieAnn Hing (649)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 7-9 and 12-15, 2024.

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00097058/ CI #2723-000027-23; Intake: #00105036/ CI #2723-000032-23 was related to an outbreak.
- Intake #00100084/ CI #2723-000029-23 was related to prevention of abuse and neglect.
- Intake #00100912/ CI #2723-000030-23 was related to improper care of a resident.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that the policy directive that applies to the long-term care home was complied.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective March 31, 2023, licensees were required to ensure that the masking requirement set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", was followed. The document required that masks were worn indoors in all resident home areas.

Rationale and Summary

A direct care staff was observed exiting a resident's room not wearing a mask covering their nose.

The staff acknowledged that their mask was not worn properly. After speaking with the inspector, they immediately adjusted the surgical mask to fit the proper way.

A registered staff and Infection Prevention and Control Lead (IPAC) both stated that the staff were expected to wear a mask covering their nose.

There was an increased risk of transmission of infection to staff and residents when staff did not properly don a surgical mask in resident home areas.

Sources: Observations; Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes; interviews with direct care staff, registered staff and IPAC Lead.

[741674]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident's responses to skin and wound interventions were documented.

Rationale and Summary

A resident was identified to have a hematoma. A registered staff completed a pain assessment, and it was noted that resident was provided with scheduled medication two hours later.

A registered staff stated that the resident was provided with an alternative intervention related to the hematoma even though documentation was not completed. The staff and the Director of Nursing Care (DONC) both acknowledged that the expectation was for staff to document the resident's response to the interventions.

Failure to document the resident's responses may put the resident at risk of delayed monitoring.

Sources: Resident's electronic medication Administration record (e-MAR) and progress notes; Interviews with registered staff members and DONC

[741674]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

Rationale and Summary

A resident was sitting in their wheelchair with the incorrect type of transfer equipment behind them. This was reported to the charge nurse and an investigation was immediately initiated.

The resident's care plan specified that the resident required a type of transfer equipment.

The home's investigation revealed that two direct care staff failed to use the correct type of transfer equipment during the resident's transfer. The direct care staff acknowledged the wrong type of transfer equipment was used to transfer the resident. They stated that the resident did not complain of pain during the transfer when the incorrect type of transfer equipment was used. The direct care staff did not report to the charge nurse that the incorrect type of transfer equipment was used to transfer resident. The DONC acknowledged that the incorrect type of transfer equipment was used to transfer the resident.

The home failed to utilize the correct type of transfer equipment during transfer of the resident.

Sources: Resident’s care plan, progress notes and home's investigation notes; and interviews with direct care staff and DONC.

[741674]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that a resident's behaviour strategies were implemented.

Rationale and Summary

Resident #001’s care plan specified for them to be encouraged to apply an intervention for an identified trigger.

A registered staff acknowledged they received a report from a direct care staff that resident #001 was observed hitting another resident. The registered staff stated resident #001 hit another resident because of the behaviour that resident was exhibiting. The registered staff acknowledged they had not implemented the intervention for resident #001 when they were made aware of this incident, because the intervention was not available. Personal Expression Lead and DONC both stated resident #001's responsive behaviour intervention should have been implemented and documented by the nursing team.

Failure to implement responsive behaviour strategy for the first resident resulted in altercation between residents.

Sources: Resident's care plan and progress notes; and interviews with registered staff, Personal Expression Lead and DONC.

[741674]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, additional requirement 9.1 (b) of the "IPAC Standard for Long Term Care Homes April 2022 revised September 2023" directs homes to ensure proper hand hygiene, including but not limited to, at the four moments hand hygiene. Also, additional requirement 9.1 (f) of the "IPAC Standard for Long Term Care Homes April 2022 revised September 2023" directs homes to ensure proper removal of personal protective equipment (PPE)".

Rationale and Summary

A direct care staff did not follow hand hygiene after resident/resident environment contact or remove their PPE following provision of care for a resident. The resident's room had posted signage that they were on contact precaution.

The direct care staff was observed exiting the resident’s room wearing PPE. Their PPE was not removed after they exited the resident's room and obtained a mechanical lift that was outside of the resident's room in the hallway.

The home's policies titled "Personal Protective Equipment" and "Hand Hygiene" directed staff to remove gloves when walking through hallways and common spaces and cleanse hands after giving care to the resident.

The direct care staff acknowledged that they did not remove their PPE or perform hand hygiene upon exiting the resident's room because the mechanical lift was in close proximity. A registered staff and Infection Prevention and Control (IPAC) Lead both stated that staff were expected to follow the home's IPAC policies and remove PPE then perform hand hygiene before proceeding to touch any equipment including the mechanical lift.

There was an increased risk of infection transmission when staff did not remove and dispose of appropriate PPE or perform hand hygiene upon exiting the resident's room.

Sources: Observations; PPE and Hand Hygiene Policy; Interviews with direct care staff, registered staff, and IPAC lead.

[741674]

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 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

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 there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023" (IPAC Standard). Specifically, the IPAC Lead failed to ensure that the hand hygiene program included 70-90% alcohol-based hand rub (ABHR) as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

Observation during the initial tour revealed that there was an expired ABHR on the table next to the visitor sign in sheet on the main floor. The IPAC lead acknowledged that the expired ABHR should not have been used in the LTCH. The next day, in a follow up observation the expired ABHR had been removed.

Sources: Observations; interviews with IPAC lead.

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