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: July 17, 2024

Inspection Number: 2024-1219-0002

Inspection Type:
Critical Incident

Licensee: Schlegel Villages Inc.

Long Term Care Home and City: Fairview Nursing Home, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 24, 25, 28, 2024, and July 9, 10, 11, 2024

The inspection occurred offsite on the following date(s): July 12, 2024

The following intake(s) were inspected:

- Intake #00109784/Critical Incident (CI) related to resident to resident abuse;
- Intake #00116706/CI related to a disease outbreak and;
- Intake #00118160/CI related to a resident fall with injury.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that resident #001 was protected from abuse by resident #002.

O.Reg 246/22, s.2. (1), defines "emotional abuse" as, any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; ("mauvais traitements d'ordre affectif"); and "verbal abuse" as, any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitements d'ordre verbal").

Rationale and Summary

The home submitted a critical incident (CI) to the Ministry of Long-Term Care

(MLTC), related to an allegation of abuse by resident #002 towards resident #001.

Resident #002 was transferred from another resident home area (RHA) due to an altercation with another co resident. The plan of care documented a specified trigger for resident #002 and would escalate to a particular responsive behaviour towards other residents. Resident #002 told the General Manager (GM) and the Personal Expressions Lead (PEL) prior to their transfer to another RHA that the specified trigger would irritate them and was advised to call the staff with any concerns.

Since resident #002's move to the RHA, they made derogatory and threatening remarks to resident #001.

A Registered Nurse (RN) and two Personal Support Workers (PSWs) acknowledged that resident #001 endured verbal and emotional abuse from resident #002. Resident #002 would make derogatory remarks and profanities at resident #001. The PSWs indicated that resident #002 would always be yelling and screaming at resident #001 and physically threatened them due to the specified trigger. Resident #002 was overheard by staff threatening resident #001 when staff were not present. The PSWs stated that resident #001 feared resident #002. A PSW indicated that resident #001's facial expression would change when threatening remarks were made. Another PSW stated that resident #001 complained to them many times that they were bothered by resident #002 and was scared of them due to the remarks and threats resident #002 made.

The staff acknowledged that there was a change in resident #001 when resident #002 was in the home.

Resident #001 stated they did not feel safe in the home when resident #002 was in the home and was afraid of them.

Resident #001 did not feel safe in the home which affected their emotional well-being.

Sources: Review of CI report, residents #001 and #002's clinical records, External Consult note, home's investigation notes; and interviews with resident #001, RN, two PSWs and other staff. [665]