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: October 8, 2024

Inspection Number: 2024-1219-0003

Inspection Type:
Complaint
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): September 18 - 20, 23 - 25, 2024

The following Complaint intake(s) were inspected:
· Intake: #00121150 – Related to concerns of neglect, skin and wound care, improper transfer and dietary care

The following Critical Incident (CI) intake(s) were inspected:
· Intake: #00122431 – [CI #2723-000010-24/#2723-000011-24] – Related to an improper transfer resulting in injury
· Intake: #00123215 – [CI #2723-000012-24] – Related to a fall incident resulting in injury

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

Skin and Wound Prevention and Management
Resident Care and Support Services

Infection Prevention and Control
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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident sets out clear directions to staff and others who provided direct care to the resident, specifically related to assistive equipment for a specific task.

Rationale and Summary
A resident's care plan indicated two different types of assistive equipment could be used for a specific task. Multiple assessments indicated, however, the resident was not safe to use one of the assistive equipment listed.

Staff were aware to use the assistive equipment indicated on the assessments, and

not the type that was deemed unsafe. Two Personal Support Workers (PSWs) were observed using the correct assistive equipment when performing the task. A Registered Practical Nurse (RPN) also indicated the correct assistive equipment to be used when staff were performing the specific task.

The Director of Nursing Care (DNC) acknowledged that the plan of care did not set out clear directions to staff and others who provided direct care to the resident, regarding the correct assistive equipment to use when performing the specific task.

The care plan was revised to indicate that the resident was not safe for one specific type of assistive equipment, and using it for the specific task was removed from the care plan.

Sources: Observation**,** Resident's clinical records, Interviews with PSWs, RPN and DNC.

Date Remedy Implemented: September 24, 2024

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure a resident's substitute decision-maker (SDM) was

given an opportunity to participate in the development and implementation of the resident's plan of care when a specific condition worsened.

Rationale and Summary
The resident was admitted to the home with a specific condition.

On multiple reassessments, the specific condition was shown to gradually worsen.

An RPN indicated and documented they left a voicemail with the SDM on a specific date when the specific condition had worsened, however, the SDM indicated they did not receive any voicemail notification.

There was no further documentation in the resident's clinical records indicating that the SDM was informed of the resident's worsening specific condition.

The DNC indicated the SDM should have been informed each time the specific condition had worsened and confirmed that the documentation by nursing staff did not indicate this happened.

Failing to ensure that the SDM was notified each time the resident's specific condition worsened, limited the SDM's opportunity to be involved in the resident's plan of care.

Sources: Resident's clincal records, home's Complaint Response Form, Interview with DNC.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure a resident's plan of care was followed.

Rationale and Summary
A resident's plan of care indicated actions to be taken given a specific medical issue.

On a specific date, the resident presented with signs and symptoms consistent with this specific medical issue.

The home investigated this incident and determined the Registered Nure (RN) did not correctly identify the specific medical issue and therefore, the actions indicated in the resident's plan of care did not occur.

The DNC confirmed the resident presented with the specific medical issue and that the actions indicated in the resident's plan of care should have been followed.

Failing to ensure the actions detailed in the resident's plan of care were followed when the specific medical issue presented, resulted in their plan of care not being followed.

Sources: Resident's clinical records, home's investigation notes, Interview with DNC.

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #004 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 the assessment and reassessments of a resident's specific condition were documented.

Rationale and Summary
The resident was admitted to the home with a specific condition.

As per the home's program-specific policy, the specific condition was assessed upon admission and reassessed multiple times at a regular interval.

For each assessment and reassesment, the nursing staff in the home did not document a parameter of the specific condition.

An RPN acknowledged that the specific condition had this parameter but that the home's assessment tool did not allow for this parameter to be documented.

An external specialized nurse assessed the resident's specific condition when it had deteriorated and documented on this parameter.

The DNC indicated the parameter for the specific condition should have been documented, and that this was a gap in the home's assessment and reassessments of the resident's specific condition.

Failing to ensure the assessment and reassessments of the resident's specific

condition was documented posed the risk for inadequate monitoring.

Sources: Resident's clinical records, Interviews with an RPN and DNC.

COMPLIANCE ORDER CO #001 TRANSFERRING AND POSITIONING TECHNIQUES

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1) Conduct, at minimum, an audit of three mechanical lift transfers per week performed by a specific PSW for a period of three weeks following the service of this order. At least one of the transfers every week should involve the specific resident.
2) Maintain a record of the audits in point one, including the dates, who conducted the audits, staff and residents audited, results of audits and actions taken in response to the audit findings.
3) Develop and implement an action plan to ensure long-term sustainability of safe transferring and lift techniques when assisting residents.
4) Retain all records for points two and three until the Ministry of Long-Term Care (MLTC) has deemed this order has been complied.

Grounds

The licensee has failed to ensure that a Student PSW used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident's care plan at the time of the incident indicated they required an assistive equipment with two team members for a specific task to be completed.

A Student PSW attempted to independently and manually perform this task with the resident. As a result, the resident had a fall resulting in a change in health status.

A PSW acknowledged that they demonstrated to the Student PSW how to manually perform this task with the resident. The PSW acknowledged that they was aware of multiple occasions where the Student PSW attempted to independently and manually perform this task.

The DNC acknowledged that when the Student PSW performed this task independently and manually, they did not use safe transferring techniques.

Failure of the Student PSW to use safe transferring techniques when assisting the resident resulted in an injury.

Sources: Resident's clinical records, Home's investigation notes, Interviews with PSW and DNC.

This order must be complied with by October 31, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Compliance Order (High Priority) was issued in inspection #2022-1219-0003 to O. Reg. 246/22, s. 40 Transferring and positioning techniques on December 2, 2022

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

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;
(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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.