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: November 20, 2024

Inspection Number: 2024-1219-0004

Inspection Type:
Complaint
Critical Incident
Follow up

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): November 7-8, 12-14, 2024.

The following intake was inspected in this follow-up inspection:

- Intake: #00128862 was related to transferring and positioning.

The following intake was inspected in this complaint inspection:

- Intake: #00128962 was related to alleged physical abuse.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

- Intake: #00128797 [CI #2723-000016-24] was related to physical abuse between residents.
- Intake: #00130952 [CI #2723-000017-24] was related to an acute respiratory infection outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2024-1219-0003 related to O. Reg. 246/22, s. 40

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

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

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 has failed to protect a resident from physical abuse by another resident.

Under the Fixing Long-Term Care Act (FLTCA), 2021, the Ontario Regulation 246/22, section 2 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary
Resident #001 attempted to enter resident #002's room and an altercation between the residents occurred.

Resident #001 pushed on the door that led to resident #002 falling and sustaining an injury, resulting in a change in an injury and pain.

Staff confirmed resident #001's actions constituted physical abuse of resident #002.

In failing to protect resident #002 from physical abuse by resident #001, resident #002 sustained a physical injury.

Sources: Residents' clinical records, Interviews with staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to monitor symptoms that indicated the presence of infection for residents every shift.

Rationale and Summary
Residents listed on the home's outbreak list were expected to be monitored every shift for symptoms of infection.

Two residents did not have documentation related to symptoms monitored for one shift.

Staff confirmed that there was no documentation completed for both residents.

Sources: Residents' clinical records, Interviews with staff.

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