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

Public Report

Report Issue Date: September 5, 2025
Inspection Number: 2025-1219-0003
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): August 28, 29, 2025 and September 2, 3, 5, 2025

The inspection occurred offsite on the following date(s): September 4, 2025

The following intake(s) were completed during this Critical Incident (CI) Inspection:

-Intake: #00146415 - [CI: 2723-000005-25] and Intake: #00149983 - [CI: 2723-000011-25] – were related to Disease Outbreak

-Intake: #00149895 - [CI: 2723-000010-25] – was related to Medication Administration

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

(i) Specifically, IPAC Standard for Long-Term Care Homes (LTCH), s. 9.1 (b) states that the licensee shall ensure that Routine Practices and Additional Precautions were followed in the IPAC program. At minimum, Routine Practices shall include: hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

During an observation, a Recreation Aide (RA) , a Personal Support Worker (PSW) and a Housekeeper (HK) did not perform hand hygiene before and after contact with a resident and the resident's environment and acknowledged the omission.

Sources: Inspector's observations, IPAC standards for LTCHs, April 2022 (Revised September 2023), LTCH hand hygiene policy #Tab 06-13, and interviews with the RA, the PSW, the HK, and the Associate Director of Nursing and Personal Care (ADNC)/IPAC Lead.

(ii) Specifically, IPAC Standard for LTCHs, s. 4.3 states that the licensee shall ensure that following the resolution of an outbreak, the Outbreak Management Team (OMT) and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices.

The LTCH did not meet the requirements of s. 4.3 of the IPAC Standard, as it failed to conduct a debrief with the OMT and did not provide evidence of a summary of findings and recommendations following two respiratory outbreaks. The ADNC/IPAC Lead confirmed that the debriefs were not completed.

Sources: IPAC standards for LTCHs, April 2022 (Revised September 2023), and interview with the ADNC/IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The Licensee failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

A resident was given multiple high-risk medications by a Registered Practical Nurse (RPN), although these medications were not prescribed for the resident. The resident experienced a negative health outcome requiring further assessment. The RPN admitted to not verifying the resident's identity before administration.

Sources: Resident's clinical records, LTCH's investigation notes, and interviews with the RPN and other staff.