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

Central West District
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Original Public Report

Report Issue Date: November 22, 2023	
Inspection Number: 2023-1491-0004	
Inspection Type: Critical Incident	
Licensee: Fairview Mennonite Homes	
Long Term Care Home and City: Fairview Mennonite Home, Cambridge	
Lead Inspector Janis Shkilnyk (706119)	**Inspector Digital Signature** Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.11.30 06:16:41 -05'00'
Additional Inspector(s) Kailee Bercowski (000734)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6, 7, 8, 9, 2023

The following intake(s) were inspected:

- Intake: #00087843 - related to allegations of resident abuse.
- Intake: #00089589 - related to an incident of responsive behavior resulting in resident injury.
- Intake: #00090603 - related to improper care.
- Intake: #00093512 - related to resident fall with injury.
- The following intakes were completed in this inspection: Intake #0084094, and Intake #0093486, related to resident falls.

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
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)

The licensee has failed to ensure residents were protected from abuse.

"Emotional abuse" is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. O. Reg. 246/22, s. 2 (1).

In accordance with section 154(3) of FLTCA, where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection.

Rationale and Summary

A) A resident required assistance with their care.

A staff member assessed a resident in the hall when privacy was required. The staff member stated they would not provide needed care to the resident. After the resident was taken to their room, the staff member entered the resident's room pushing them and making an insulting remark while speaking in the third person.

The resident immediately had a negative emotional reaction to the incident.

The Director of Care (DOC) stated that after completing an investigation into the incident the concerns brought forth were deemed as resident abuse.

This incident of emotional abuse caused moderate impact to the resident as they experienced emotional distress.

Sources:

Review of clinical records, interview with DOC, PSW student, Critical Incident Summary (CIS), home's investigation report.

B) A resident required extensive assistance for care.

A staff member refused to provide care to a resident when the resident had requested care.

The staff member spoke profanity to the resident.

The resident experienced emotional distress at the time of the incident.

The Director of Care (DOC) stated that after completing an investigation into the incident the concerns brought forth were deemed as resident abuse.

This incident of emotional abuse caused moderate impact to a resident as they experienced emotional distress.

Sources:

Review of resident clinical records, interview with DOC, PSW student, Critical Incident summary, homes investigation report.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that allegations of resident abuse were reported to the Director immediately.

Rationale and Summary

The home received allegations of abuse towards residents.

The alleged incidents were not reported to the Director immediately.

The Director of Care (DOC) confirmed that the expectation for reporting alleged incidents of abuse/neglect of residents to the Director was immediate.

Potential risk of harm to residents may have occurred as the Director was unable to

take action, if required.

Sources:

critical incident summary, home's investigation report, interview with DOC.

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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

The licensee failed to ensure safe positioning techniques were used when a resident was assisted with care needs.

Rationale and Summary

A resident required total assistance from staff with activities of daily living. They required two-person total assistance with transferring and care.

A staff member assisted a resident with care alone.

During the provision of care, the resident fell and sustained an injury and required transfer to hospital for treatment.

The Director Of Care (DOC) said they considered it unsafe when the staff member

assisted the resident with care alone. Care for the resident should have been provided by two persons.

Sources:

Interviews with staff; review of Critical Incident Report, and the resident's clinical records.

WRITTEN NOTIFICATION: Required Programs: Falls Prevention and Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with their fall prevention and management program when an assessment was not completed for a resident.

In accordance with O. Reg. 246/22 s. 11. (1) (b), the licensee shall ensure that any actions taken with respect to a resident under a program, including relevant procedures, provides for methods to reduce risk and monitor outcomes, where required, and are complied with.

If a resident experienced an unwitnessed fall, the home's policy directed staff to initiate a specific assessment to monitor for signs of a injury.

Rationale and summary

A resident had an unwitnessed fall.

After their fall, staff documented initiating an assessment. They also documented signs and symptoms of injury in the progress notes.

The Director of Care (DOC) said staff were unable to locate or confirm if the specific assessments had been completed for the resident related to their fall.

When assessments were not completed for the resident, they were at risk of further injury going undetected.

Sources:

Interview with DOC, Falls Lead, and other staff; Fairview Mennonite Home's Falls Prevention and Management Program REF# NM005190.00, and Policy for Head Trauma REF# NM005200.00; the resident's clinical records.

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WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with directions for use specified by the prescriber when a resident did not receive medication as ordered.

Rationale and Summary

A resident sustained an injury.

A medication had been prescribed for this resident that would have assisted with discomfort from this injury.

The resident's documentation showed that medication was not given as prescribed for nonverbal expressions of discomfort.

The Director of Care (DOC) stated that they would expect pain medication be given as prescribed to the resident when the resident had expressions of discomfort.

The home's failure to ensure that a resident received medication as directed by the prescriber may have led to the potential of an increase in the resident's discomfort.

Sources:

Review of the resident's clinical records, a resident electronic medication administration record (EMAR), interview with DOC.

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