Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2019	2019_759502_0010	000411-18, 002248-18, 004824-18, 011704-18, 019664-18, 027370-18, 004222-19, 004626-19, 005971-19, 007259-19, 008423-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

Fairview Nursing Home
14 Cross Street TORONTO ON M6J 1S8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIENNE NGONLOGA (502), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 23 - 26, 29 - 30, May 1 - 3, and 6, 2019.

**The following intakes were completed in this Critical Incident System Inspection:
Log #004824-18 (CIS #2723-000007-18) and log #027370 (CIS #2723-000029-18) related to missing resident,
log #002248-18 (CIS #2723-000003-18), related to responsive behaviours,
log #004626-19 (CIS #2723-000005-19) and log #008423-19 (CIS#2723-000011-19) related to resident to resident abuse, and
log #004222-19 (CIS #2723-000004-19), log #005971-19 (CIS #2723-000006-19) and log #007259-19 (CIS #2723-000009-19) related to falls prevention.**

**The following intakes were completed in this Critical Incident System Inspection:
Log #000411-18 (CIS #2723-000001-18), Log #011704-18 (CIS #2723-000009-18) and Log #019664-18 (CIS #2723-000016-18) related to falls prevention.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Neighborhood Co-ordinator (NC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Home Physician, Physiotherapist (PT), Kinesiologist (KT) and residents.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC), in regard to resident #005's frequent falls. Resident #005 had a fall on an identified date, they were transferred to the hospital and returned home the next day. Two days after the previous fall, the resident had another fall, they were transferred to the hospital and passed away one day after.

Review of resident #005's progress notes indicated the resident was assessed by the Physiotherapist (PT) #104 after the resident experienced a fall on an identified day. PT #104 recommended specified care equipment for the resident. This was confirmed during an interview with PT #104.

Review of resident #005's care plan indicated the specified care equipment was not included in the interventions for the resident's fall risk focus.

In an interview, Kinesiologist (KT) #105, who is also the lead for the falls prevention program, stated that the home did not use the specified care equipment as fall prevention strategy; therefore, similar care equipment would not be implemented for any resident. KT #105 also stated that they were not aware of the PT's recommendation of the specified care equipment for resident #005, and the PT was not informed that the above recommendation was not implemented.

In an interview, PT #104 stated they were not aware of the recommendation of the specified care equipment for resident #005 was not implemented.

In an interview, Administrator #109 stated that when the PT's recommendation was not implemented, the team should collaborate with each other in seeking out alternatives. Administrator #109 confirmed that there was a gap in communication among the multidisciplinary team members in regard to resident #005's care plan development and implementation. [s. 6. (4) (b)] (507)

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CIS report was submitted to the MOHLTC in regard of an incident where resident #007 pushed resident #008 resulting in injury.

Review of resident #007's progress notes indicated that on an identified day and time, resident #007 exhibited a specified behaviour toward resident #008. Resident #008 fell and sustained identified injury. The resident was transferred to the hospital and returned to the home the next day with a specified diagnosis.

Review of the CIS report indicated that hourly Dementia Observational System (DOS) and a Daily Tracking form, to ensure that residents #007 and #008 were not in close proximity, was initiated after the incident mentioned above.

Review of the DOS documentation record for an identified period of time indicated that the daily tracking form was not completed on 19 occasions during the day, evening and night shifts.

In an interview, NC #116 indicated that DOS documentation was initiated after the incident identified above. The NC acknowledged that staff did not complete the daily

tracking form. [s. 6. (9) 1.] (502)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

a. A CIS report was submitted to the MOHLTC related to resident to resident abuse.

Review of the CIS report and progress notes indicated that on an identified date, resident #001 exhibited specified behaviour toward resident #002.

Further review of the CIS report indicated that the alleged incident of abuse was reported two days after the home became aware of the alleged incident of abuse.

b. A CIS reports were submitted to the MOHLTC in regard of two incidents where resident #007 exhibited specified behaviours toward resident #008 resulting in injury.

Review of the CIS report and resident's progress notes indicated that on a specified date, resident #007 exhibited specified behaviours toward resident #008 while they were walking in the hallway. Resident #008 had a fall and sustained an identified injury.

Further review of the CIS report indicated that the alleged incident of abuse was reported one day after the home became aware of the alleged abuse.
In an interview, the Administrator indicated acknowledged the incident was not reported to the Director under the LTCHA immediately. [s. 24. (1)] (502)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

CIS reports were submitted to the MOHLTC respectively in regard of two incidents where resident #007 exhibited specified behaviour toward resident #008 resulting in injury.

Review of resident #007's progress notes for a four month period in 2019 indicated that resident #007 exhibited specified behaviour toward resident #008 on four different occasions, in which resident #008 sustained injury on two occasion.

Review of resident #008's Resident Assessment Instrument-Minimum Data Set (RAI-MDS) completed on an identified date indicated resident #008 was not able to recall the location of own room. Resident #008's cognitive skills for daily decision-making was severely impaired, which indicated the resident never/ rarely made decisions.

Review of the resident's current written plan of care indicated no interventions to minimize the risk of potentially harmful interactions between resident #007 and #008.

Interview with RPN #103 acknowledged that resident #008 was impaired, exhibiting specified behaviours and they did not know what they were doing. RPN indicated that resident #007 did not want resident #008 close to their spouse, they became jealous and exhibited a specified behaviour. The RPN indicated that staff monitored and redirected resident #008 when out of their room.

In separate interviews, NC #116 and ADOC #117 indicated staff were to redirect the resident. Both did not identify interventions to minimize the risk of potentially harmful interactions between residents #007 and #008. [s. 55. (a)] (502)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when informing the Director of an incident under subsection (1), (3) or (3.1) would, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the a description of the individuals involved in the incident, including, the names of any residents involved in the incident, with respect to the incident.

A CIS report was submitted to the MOHLTC in regard to resident #006 missing for more than three hours.

Review of the CIS report, resident #006's name was not included in the report. This was confirmed with Administrator #109 during an interview. [s. 107. (4) 2. i.] (507)

Issued on this 10th day of May, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.