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
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Original Public Report

Report Issue Date: March 16, 2023	
Inspection Number: 2023-1219-0005	
Inspection Type: Follow up Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Fairview Nursing Home, Toronto	
Lead Inspector Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.03.16 14:02:09 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 28, March 1, 2, 3, 2023

The following intake(s) were inspected:
- Intake: #00015910 – CIS #2723-000025-22 – related to prevention of abuse and neglect
- Intake: #00019070 - Follow-up – related to transferring and positioning technique

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1219-0003 related to O.Reg. 246/22, s. 40 inspected by Nicole Ranger (189)

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

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

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 that the resident #001 was protected from emotional and verbal abuse by PSW #103.

O. Reg 246/22, s. 2 (1) defines emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions , behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"; and defines verbal abuse as "any form of verbal communication of a threating or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well being, dignity or self worth, that is made by anyone other than a resident".

Rationale and Summary

Resident #001 reported to the Resident Support Coordinator (RSC) #104 of an incident that occurred with PSW #103, where the PSW spoke to them in an infantilizing, belittling and offensive manner. Recreation Aide #105 was present during the interaction.

PSW #103 confirmed that an incident occurred with resident #001, and that they received discipline related to verbal and emotional abuse of resident #001.

Resident #001 reported that the incident was infantilizing, belittling and offensive. The resident reported that PSW #103 no longer provides care to them.

The General Manager (GM) acknowledged that the actions PSW #103 displayed to the resident constitute verbal and emotional abuse, and disciplinary and training measures were taken.

Sources: Review of resident #001's care plan, home's investigation notes, CIS 2723-000025-22, interviews with resident #001, PSW #103, Recreation Aide #105, Resident Support Coordinator #104 General Manager and other staff.

[189]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that staff complied with the home's Prevention of Abuse and Neglect policy for mandatory reporting of resident abuse.

Rationale and Summary

The home's Prevention of Abuse and Neglect policy directed staff to report any suspicions, incidents, or allegations of neglect and/or abuse immediately to any supervisor or member of the leadership team for further investigation.

Resident #001 reported to the Resident Support Coordinator (RSC) #104 of an incident that occurred with PSW #103, where the PSW spoke to them in an infantilizing, belittling and offensive manner. Recreation Aide #105 was present during the interaction.

Recreation Aide #105 confirmed that they witnessed the interaction between the PSW and the resident, and that the incident constituted verbal/emotional abuse. Recreation Aide #105 stated that they informed the Director of Recreation about the incident. The Director of Recreation confirmed that they were aware of the incident, however no immediate action was taken to start an investigation. An investigation started once the resident reported the concern to the RSC #104.

The GM acknowledged that staff did not follow the home's prevention of abuse and neglect policy related to mandatory reporting of resident abuse.

Failure to immediately investigate delayed required investigation to be initiated.

Sources: Review of resident #001's care plan, home's investigation notes, CIS 2723-000025-22, review of home's policy titled Prevention of Abuse and Neglect, interviews with resident #001, PSW #103, Director of Recreation, Recreation Aide #105, General Manager and other staff.

[189]