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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street, 5th Floor
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Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 9, 2014	2013_159178_0026	T-687-13	Critical Incident System

Licensee/Titulaire de permis

FAIRVIEW NURSING HOME LIMITED
14 CROSS STREET, TORONTO, ON, M6J-1S8

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

SUSAN LUI (178), ERIC TANG (529), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

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

This inspection was conducted on the following date(s): November 26, 2013, December 3, 23, 24, 2013, January 2, 6, 7, 2014

This inspection included Complaint Inspection T-708-13.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing (DON), Staff Development Coordinator, registered staff, personal support workers (PSWs), residents, family members of a resident, investigating Police Detective.

During the course of the inspection, the inspector(s) reviewed resident records, reviewed home records, viewed video surveillance, observed resident care, observed snack and dining service, observed resident care areas.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 1 was protected from abuse by anyone.
Video evidence and staff interviews confirm that resident # 1 was abused by two different identified staff members on two identified dates:
On November 18, 2013, resident # 1 was slapped in the face by staff # 1 during care. The resident was slapped once with the caregiver's hand and twice more with a face cloth.
On November 19, 2013 resident # 1 was verbally and physically abused when staff # 2 mimicked the resident's vocalizations and roughly repositioned the resident's leg in bed. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observations within the home, and review of video evidence confirm that not all staff participate in the implementation of the infection prevention and control program. Review of video footage revealed the following:
-an identified personal support worker (PSW) emptied the urine from resident # 1's catheter bag into the resident's wash basin, then added urine from a urinal belonging to a co-resident before emptying the contents of the basin into the toilet. The PSW then rinsed the basin with water only, and returned it to resident # 1's cupboard. After emptying the urine from the basin the PSW proceeded to wash resident # 1's face without performing hand hygiene or changing his/her gloves in between the two tasks.
-the same PSW is observed providing care to two different residents without performing hand hygiene or changing gloves in between the two residents.

Observations made within the home during the inspection period revealed the following:
-on two different days a catheter bag was stored in a basin in resident # 3's bedside table with nothing covering the tubing which would plug directly into the residents catheter. As a result, the tubing opening may be exposed to bacteria within the basin or the bedside table, thereby potentially exposing the resident to bacteria which could cause a urinary tract infection.
-unlabeled personal care items, including a toothbrush and an electric razor were observed in the bathroom shared by two residents. [s. 229. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Staff interviews with the Director of Nursing (DON), registered staff, and personal support workers confirm that resident # 1 displayed resistance to care and aggressive behaviours towards staff during care, and therefore was only to be cared for by two staff at a time.

Video evidence and staff interviews confirm that resident # 1 was not consistently provided personal care by two caregivers at a time.
Staff interviews confirm that staff would sometimes provide personal care to resident # 1 independently when the resident was calm or when the staff member did not have a partner readily available to assist.
Video evidence confirms that resident # 1 was provided personal care by only one staff member on two separate occasions.
Staff # 2 is shown independently washing the resident's face and roughly repositioning the resident's leg on November 19, 2013, at 0500h. Staff # 2 is also observed on the video to be mimicking the resident's vocalizations.
On November 18, 2013 at 2135h staff # 1 is observed independently undressing and washing resident # 1. The resident begins to resist care and staff # 1 is observed slapping the resident in response. [s. 6. (7)]

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 care set out in the plan of care is provided to residents as specified in the plan, specifically in regards to the number of staff required to provide care to aggressive or resistant residents., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. 2007, c. 8, s. 75. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring staff
members.

Record review and staff interviews confirm that criminal reference checks are conducted on staff
members after the date of hire.

Interviews with the Director of Nursing (DON) and the Administrator confirm that when staff members are hired, a criminal reference check is initiated, but the new staff members are working with residents before the results of their criminal reference checks are received.

Records review of the five most recently hired staff members indicates that none of the five had a current criminal reference check completed before beginning work at the home.

It should be none of the five staff members whose employee records were reviewed have had any allegations of wrongdoing made against them while working in the home. [s. 75. (1)]

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 screening measures are conducted in accordance with the regulations before hiring staff, to be implemented voluntarily.

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 9th day of January, 2014

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

Susan Lin (178)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN LUI (178), ERIC TANG (529), VERON ASH (535)
Inspection No. / No de l'inspection :	2013_159178_0026
Log No. / Registre no:	T-687-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 9, 2014
Licensee / Titulaire de permis :	FAIRVIEW NURSING HOME LIMITED 14 CROSS STREET, TORONTO, ON, M6J-1S8
LTC Home / Foyer de SLD :	FAIRVIEW NURSING HOME 14 CROSS STREET, TORONTO, ON, M6J-1S8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~JUDY DONNELLY~~ Pamela Gauci

To FAIRVIEW NURSING HOME LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse by anyone.

Plan shall be submitted to Inspector #178, Susan Lui, at susan.lui@ontario.ca by January 31, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that resident # 1 was protected from abuse by anyone.

Video evidence and staff interviews confirm that resident # 1 was abused by two different identified staff members on two identified dates:

On November 18, 2013, resident # 1 was slapped in the face by staff # 1 during care. The resident was slapped once with the caregiver's hand and twice more with a face cloth. During the incident staff # 1 is observed independently undressing and washing the resident. The resident begins to resist care and staff # 1 is observed slapping the resident in response.

On November 19, 2013 resident # 1 was verbally and physically abused when staff # 2 mimicked the resident's vocalizations and roughly repositioned the resident's leg in bed. Staff # 2 is shown on video independently washing the resident's face and roughly repositioning the resident's leg onto a pillow. Staff # 2 is also observed on video mimicking the resident's vocalizations.

Both of these abuse incidents occurred while the resident was being cared for independently by one staff member in spite of the fact that personal care was to be provided to this resident by two staff at a time. Interviews with the DON, registered staff and PSWs confirm that because resident # 1 displayed resistance to care and aggressive behaviours towards staff during care, personal care was to be provided by two staff at a time.
Staff interviews confirmed that staff would sometimes provide personal care to resident # 1 independently when the resident was calm or when the staff member did not have a partner readily available to assist.

(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff participate in the implementation of the infection prevention and control program, specifically in regards to hand hygiene and the emptying and storage of residents' urinary catheter bags.

Plan shall be submitted to Inspector #178, Susan Lui, at susan.lui@ontario.ca by January 31, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observations within the home, and review of video evidence confirm that not all staff participate in the implementation of the infection prevention and control program.
Review of video footage revealed the following:
-an identified personal support worker (PSW) emptied the urine from resident # 1's catheter bag into the resident's wash basin, then added urine from the urinal belonging to a co-resident before emptying the contents of the basin into the toilet. The PSW then rinsed the basin with water only, and returned it to resident # 1's cupboard. After emptying the urine from the basin, the PSW proceeded to wash resident # 1's face without performing hand hygiene or changing his/her gloves in between the two tasks.
-the same PSW is observed providing care to two different residents without performing hand hygiene or changing gloves in between the two residents.

Observations made within the home during the inspection period revealed the following:
-on two different days a catheter bag was stored in a basin in resident # 3's bedside table with nothing covering the tubing which would plug directly into the residents catheter. As a result the tubing opening may be exposed to bacteria within the basin or the bedside table, thereby potentially exposing the resident to bacteria which could cause a urinary tract infection.
-unlabeled personal care items, including a toothbrush and an electric razor were observed in the bathroom shared by two residents.

(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

and the Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of January, 2014

Signature of Inspector / Signature de l'inspecteur : Susan Lui (178)

Name of Inspector / Nom de l'inspecteur : SUSAN LUI

Service Area Office / Bureau régional de services : Toronto Service Area Office