Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 1, 7, 8, 2011	2011_077109_0002	Follow up

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 SQUIRES (109)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with Judy Donnelly Administrator, Natalie Molin Director of Care, Imogene Biggs RPN, Theresa Matteer PSW.

During the course of the inspection, the inspector(s) Reviewed the health record for an identified resident. Reviewed medication records for an identified resident.

The following Inspection Protocols were used in part or in whole during this inspection:

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
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.)

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 subsections:

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 sayants :

1. Jun 01, 2011 - 16:16 - A resident has a treatment order on MAR which states to complete a "Pain assessment 15th and 30th of the month".
The pain assessments have not been completed for the resident since February 11, 2011.

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 by ensuring that plans of care provide clear and current directions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits sayants :

1. Jun 01, 2011 - 12:55 - Inspector noted that a resident did not receive her Monthly dose of Actonel 150 mg. Inspector spoke to the RPN about the missing signature for the drug. RPN stated that the drug was not available for administration as it did not come in from pharmacy after it was ordered and therefore the drug was not administered.

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 by ensuring that medications prescribed once a month are available for administration to the residents. , to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits sayants :

1. Jun 01, 2011 - 16:24 - A resident has not been monitored to determine her response, and whether or not the drug is effective since February 11, 2011.
A treatment order states to complete pain assessments on the 15th and 30th of each month has not been completed.

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 conduct assessments and monitoring of resident's with identified pain to determine effectiveness of the drug regime. , to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits sayants :

1. A resident's narcotic pain patch was noted to be missing on 2 separate occasions.
There was no indication as to how long the patches were missing.
There was no corrective action taken in response to these medication incidents. 135(2)(b)
2. There is no documented record describing the immediate action taken to assess the resident for either of these medication incidents. 135(1)(a)
There was no medication incident reported to the Director of Nursing, the Medical Director, the prescriber, or the resident's family.135(1)(b)
There was no corrective action taken in response to these medication incidents. 135(2)(b)

Issued on this 8th day of June, 2011

[redacted]

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