Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 18, 2021	2021_650565_0013	024134-20, 005298-21, 008901-21	Complaint

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

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 26, 29, 30, August 3-5, and 9-13, 2021.

The following intakes were completed in this complaint inspection:
- two intakes were related to prevention of abuse and multiple care concerns, and
- one intake was related to medication administration, continence care and bowel management.

The following inspection was completed concurrently with this complaint inspection:
- Inspection #2021_650565_0012.

During the course of the inspection, the inspector(s) spoke with the General Manager (GM), Acting Director of Nursing Care (Acting DNC), Personal Expression Lead & Assistant Director of Nursing Care (PELADNC), Director of Environmental Services (DES), Acting Director of Recreation (Acting DR), Registered Nurses (RNs), Neighbourhood Coordinators (NCs), Registered Dietitian (RD), Social Worker (SW), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreation Aide (RA), Housekeeping Staff, Residents, and Family Members.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

Inspector, April Chan (#704759) attended this inspection during orientation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

1 WN(s)
1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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 saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

a. A physician order for a medication was created for the resident four times daily for a number of days. One dose of the medication was omitted and it was discovered by the nurse on the next shift. Without receiving the direction from the physician, the nurse made up the dose by administering an additional dose to the resident after the course of medication was completed that day.

Sources: Resident’s progress notes, physician order, eMAR; home’s medication incident records; interviews with the family, RN and PELADNC.

b. A physician order for another medication was created for the resident. The medication was found missing and it was not ordered until the nurse on the next day contacted the pharmacy. Since the pharmacy had dispatched the medication for the day, the home received the medication on the following day. The original physician order was not revised during these days and the medication was not administrated to resident for two days as required.

Sources: Resident’s progress notes, physician order, eMar; home’s complaint records; interview with the family and PELADNC. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 20th day of August, 2021

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

Original report signed by the inspector.