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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 7, 2013	2013_159178_0002	T-006-13/T-1268-12/T-1475-12	Complaint

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)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 22,23,24, February 1, 2013

This inspection also addressed Log #s 1767-12 and 2047-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Associate Director of Nursing, Registered Staff, Personal Support Workers, residents of the home.

During the course of the inspection, the inspector(s) observed resident care, observed home environments, reviewed resident and home records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Medication

Personal Support Services

Responsive Behaviours

Skin and Wound Care

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.) 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 :

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1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.
Staff and resident interviews, as well as review of home's records, indicate that on an identified date Resident # 1 was provided with a medication which had been previously discontinued by his physician. The resident identified the error and did not take the medication. [s. 131. (1)]

2. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
Staff and resident interviews and review of home records indicate that on an identified date Resident # 1 was not provided with all of his/her medications as prescribed. The resident noted the missing medication and informed the staff member. The missing medication was later found to have fallen out of a damaged medication pouch. The staff member in question failed to examine the medication pouch to ensure that all medications were correct. The resident did eventually receive the medication as prescribed. [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
a) no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, and that
b) drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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Issued on this 28th day of February, 2013

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

Susan Lin (178)