



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
 Direction de l'amélioration de la performance et de la conformité

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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 28, 29, 2011	2011_077109_0008	Critical Incident

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 Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of care, PSW staff, Director of Resident and Family Services.

During the course of the inspection, the inspector(s) Conducted walk through of care units. Reviewed health record. Reviewed policy and program for falls prevention.

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

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Definitions
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. 15. Accommodation services
Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits sayants :

1. Inspector checked the posey chair alarm for an identified resident. The alarm was attached to her wheelchair. The alarm was not functioning because there are no batteries in place.
2. Inspector checked the posey chair alarm for another identified resident. The posey alarm was not functioning as there were no batteries in the unit.
3. An identified resident fell after getting out of the wheelchair. The wheelchair was equipped with a posey chair alarm. The progress note for the date of the incident states that "the posey alarm provided for the chair did not sound as it does not have batteries". [s15(2)(c)].

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 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. The plan of care for a resident includes the use of a chair sensor to the seat of the wheelchair/chair while up and check every shift to ensure it is functioning.
The resident fell to the floor resulting in injury and transfer to the hospital.
The posey chair alarm was not working because there were no batteries in the unit as stated in the progress note on the date of the incident.
The plan of care to ensure the unit was functioning every shift was not carried out as specified in the plan of care.

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 plans of care for residents with posey alarm units in place are followed and alarm units are functioning safely, to be implemented voluntarily.



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
prévus le Loi de 2007 les
foyers de soins de longue

Issued on this 18th day of August, 2011

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

A handwritten signature in black ink, appearing to be "S. J. [unclear]", written within a rectangular box.



**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 SQUIRES (109)
Inspection No. / No de l'inspection :	2011_077109_0008
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 28, 29, 2011
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

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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*

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2). Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007,
c. 8, s. 15 (2).

Order / Ordre :

The licensee will replace batteries for all chair alarm units currently in use in the home.
The licensee will develop a system of ensuring that all chair alarm units in use for falls prevention are in a safe working condition at all times.

Grounds / Motifs :

1. A resident fell after getting out of the wheelchair. The wheelchair was equipped with a posey chair alarm. The progress note for the date of the incident states that "the posey alarm provided for the chair did not sound as it does not have batteries". (109)
2. Inspector checked the posey chair alarm for a resident. The posey alarm was not functioning as there were no batteries in the unit. (109)
3. Inspector checked the posey chair alarm for another resident. The chair alarm was attached to the resident's wheelchair. The alarm was not functioning because there are no batteries in place. (109)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2011



**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*

REVIEW/APEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

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 and the

Director

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

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 18th day of August, 2011

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

SUSAN SQUIRES

Service Area Office /

Bureau régional de services : Toronto Service Area Office