



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 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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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jul 4, 6, Aug 5, 9, 2011; 2011_077109_0010; 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, Registered Staff, PSW staff, Family Member.

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

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

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Table with 2 columns: Definitions, Définitions. Lists abbreviations for WN, VPC, DR, CO, WAO in both English and French.

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. 6. Plan of care
Specifically failed to comply with the following subsections:**

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

- (a) the planned care for the resident;**
- (b) the goals the care is intended to achieve; and**
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

- (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and**
- (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

Findings/Faits sayants :

1. There was no plan of care developed to set out clear directions to the staff and others who provide care to an identified resident in response to an external specialists recommendations to ensure comfort during provision of care.[6 (1) (c)]
2. The information provided by a specialist was not considered and/or made available to the staff providing the direct care for this resident.

This information was not collaborated between the staff and others involved in the care of the identified resident in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [6(4)(a)]

3. A resident was seen by another specialist. The recommendations from the specialist were not considered in assessment and planning of care for this resident. [6(4)(a)]

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to
Director**

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits sayants :

1. A residents family member reported to the charge nurse that the resident had been abused by the staff. The licensee did not report the allegation of abuse to the Ministry of Health.[s24(1)2]



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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 all allegations of abuse are reported to the director, to be implemented voluntarily.

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. Gu" or similar, written over a white rectangular background.