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 4, 2021	2021_754764_0015	014731-20, 018461-20, 018503-20, 019428-20, 010301-21, 010671-21	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
Seniors Services and Long-Term Care (Union Station) c/o 55 John Street Toronto ON M5V 3C6

Long-Term Care Home/Foyer de soins de longue durée

Fudger House
439 Sherbourne Street Toronto ON M4X 1K6

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

NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 13, 14, 15, 16, 19, 20, 21, 26 and 27, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #010671-21, Log #010301-21, Log #019428-20, Log #018461-20, Log #014731-20, related to the fall prevention program and Log #018503-20, related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers, Infection Prevention and Control (IPAC) Nurse Manager, Building Service Manager, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector conducted observations of IPAC practices in the home, staff and resident interactions and provision of care, reviewed resident health records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to one resident, as specified in the plan.

The resident's care plan showed that staff were to ensure that specific equipment was to be in place and in working order to manage the resident's fall risk.

Inspector #764's observation with RN #111 and with PSW #117, revealed that the above mentioned equipment was not working.

RN #111 stated the equipment was not working for one week, due to a lack of battery. PSW #117 stated there was a problem with the connection to the device.

NM #110 and the DON stated that the identified equipment was to be in place and in good working order as a fall prevention measure as it was specified in the plan.

Sources: Resident care plan, Interview with RN #111, PSW #117, NM #110 and DON and Inspector's observations. [s. 6. (7)]

Issued on this 6th day of August, 2021

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

Original report signed by the inspector.