Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Original Public Report

Report Issue Date: June 2, 2023.	
Inspection Number: 2023-1546-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Fairview Lodge, Whitby	
Lead Inspector Amanda Belanger (736)	**Inspector Digital Signature** Amanda Belanger Digitally signed by Amanda Belanger Date: 2023.06.26 12:42:20 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15-18, 2023.
The inspection occurred offsite on the following date(s): May 22-25, 2023.

The following intake(s) were inspected:

- one intake related to air temperatures, and food services;
- one intake related to outbreaks, and staff shortages;
- one intake related to regarding staffing levels, resident bill of rights, and medication management; and,
- two intakes related to the discharge of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Report

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (2)

The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of the resident had occurred, immediately reported the suspicion and information upon which the suspicion was based, to the Director.

Rationale and Summary
The resident was involved in an altercation.

The internal investigation notes indicated that the resident had stated they had been hit.

There was no report made to the Director related to the situation of potential visitor to resident abuse.

The Administrator confirmed that the home had not reported the incident to the Director as an allegation of visitor to resident abuse.

There was minimal risk of harm to the resident by the allegation not being reported to Director.

Sources: The resident's progress notes; internal investigation notes; and interview with the Administrator, and other staff.

[736]

WRITTEN NOTIFICATION: Air Temperatures

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.

The licensee has failed to ensure that the temperature in one resident common area on every floor of

the home, including a lounge, dining area or corridor, was measured and documented in writing.

Rationale and Summary
The Inspector noted that the temperature logs provided by the home only contained resident rooms, it did not indicate any common areas on each floor.

The Supervisor of Environmental Services confirmed that the home was not measuring nor documenting the temperature in one resident common area on every floor of the home.

There was minimal risk of harm to the residents, as there was no extreme heat risk at the time of the non compliance.

Sources: the home's air temperature logs; interview with the Supervisor of Environmental Services.

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WRITTEN NOTIFICATION: Requirements on Licensee Before Discharging a Resident

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 161 (2)

The licensee has failed to ensure that before discharging resident #001 under subsection 157 (1) of Ontario Regulations, 246/22, the licensee had considered alternatives to discharge, and where appropriate, tried the alternatives; collaborated with the appropriate placement coordinator and other health service organizations to make alternative arrangements for accommodation, care and secure environment required by the resident; and, failed to ensure that the resident or Substitute Decision Maker (SDM) was given the opportunity to participate in the discharge planning, and that their wishes were taking into consideration.

Summary and Rationale
The resident was discharged from the long term care home.

The Director of Care (DOC) indicated that no alternatives were considered prior to discharge.

Sources: The resident's progress notes; internal investigation notes; and interview with the DOC, and other relevant staff.

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