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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 9, 2024
Inspection Number: 2024-1546-0001
Inspection Type: Critical Incident
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Fairview Lodge, Whitby

Lead Inspector	**Inspector Digital Signature**
Natalie Jubian (000744)	Natalie Jubian Digitally signed by Natalie Jubian Date: 2024.02.12 10:11:58 -05'00'

Additional Inspector(s) Miko Hawken (724)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25, 26, 29 to 31, 2024 and February 1, 2, 2024.

The following Critical Incidents were inspected:

- Intakes related to alleged resident to resident abuse.
- Intake related to an unexpected Death of a resident.
- Intake related to a medication incident.
- Intake related to resident fall with injury.

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

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

The licensee failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Summary and Rationale

A Critical Incident Report (CIR) was submitted to the Director regarding a fall and subsequent injury of a resident, which required medical intervention. The CIR indicated the resident had two falls on the same day, the first one in the morning where they fell without injury. The second fall occurred later that day where the resident was injured and transferred to hospital for further assessment.

The plan of care for the resident indicated that the staff were to ensure that the resident had their falls prevention measure in place due to a risk of falls related to their medical conditions.

The Long Term Care Home (LTCH)'s internal incident reports for both falls indicated that the resident did not have their falls prevention measure in place at the time of both falls.

Personal Support Worker (PSW) #107, Registered Practical Nurse (RPN) #108 and the Manager of Nursing Practice confirmed that at the time of the falls the resident did not have their falls prevention measure in place as per the plan of care.

Failing to ensure the resident had their falls prevention measure in place, as specified in the plan of care, could have reduced the risk of fall and subsequent injury.

Sources: CIR, the resident's clinical records, LTCH internal incident reports, Interviews with PSW #107, RPN #108 and Manager of Nursing Practice. [724]

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS BETWEEN RESIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between a resident and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary

A CIR was submitted to the Director, related to an altercation between residents #004 and #005.

Resident #004's clinical record indicated a monitoring tool was initiated for five days due to multiple physical altercations towards co-residents. The monitoring tool implemented to monitor the resident's responsive behaviours were incomplete for many shifts. Additionally, the documentation in resident #004's progress notes regarding their responsive behaviours for the five day period, did not match the monitoring tool. Staff interviews identified that the monitoring tool should have been completed by any staff member for five days, or as needed, in order to monitor a resident's responsive behaviours. Staff indicated the Registered Nurse (RN) would evaluate the monitoring tool upon completion and report the findings to the Physician.

RN #104 and the Behavioural Support of Ontario (BSO) RPN acknowledged that the monitoring tool was the appropriate tool used in the home to identify potential triggers and patterns for residents exhibiting responsive behaviours. The RN #104 confirmed that the documentation on the monitoring tool was incomplete for multiple shifts.

There was a risk of not accurately identifying resident #004's triggers and patterns of responsive behaviour due to the incomplete documentation of the monitoring tool.

Sources: CIR, the resident's clinical records, interviews with staff. [000744]