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: July 18, 2024
Inspection Number: 2024-1546-0002
Inspection Type: Critical Incident
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Fairview Lodge, Whitby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24 to 27 and July 2 to 4, 2024

The following intake(s) were inspected:

- An intake related to fall prevention.
- An intake related to prevention of abuse and neglect.
- An intake related to infection prevention and control.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control was implemented related to IPAC standards.

1) In accordance with the IPAC Standard for LTCHs, dated April 2022, section 9.1 documented that the licensee shall ensure that additional precautions are followed in the IPAC program, including the appropriate selection, application, removal and disposal.

Rationale and Summary:

1.) Nursing student #115 and Registered Practical Nurse (RPN) #102 were observed inside a resident's room which required additional precautions. Nursing student #115 was supervised by RPN #102 while the resident received treatment. . Nursing student #115 and RPN #102 were observed not wearing a gown during the procedure although the resident required precautions.

RPN #102 and the Infection Prevention and Control (IPAC) Practitioner confirmed that the resident required additional precautions and that the expectation was to

don PPE before entering the room when providing care to minimize the spread of infectious disease.

Failure to follow Personal Protective Equipment (PPE) donning/doffing protocols thus increased transmission of infection

Sources: Observations, interviews with staff and the IPAC Practitioner. [741773]

2) In accordance with Additional Requirement 6.1 under the IPAC Standard the licensee shall make personal protective equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. A resident required additional precautions and did not have gowns at the point of care.

Rationale and Summary

2.) During an observation, nursing student #115 and RPN #102 were inside a resident's room providing a treatment. Nursing student #115 and RPN #102 were not wearing a gown.

RPN #102 and the IPAC Practitioner indicated that the identified room required additional precautions and that the required PPE should be available at the point of care. The IPAC Practitioner further indicated that the required PPE was necessary to prevent transmission of infectious disease.

Failure to have the required PPE available and accessible at the point of care increased the risk of transmission of infectious disease.

Sources: Observations, interviews with staff and the IPAC Practitioner. [741773]

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59
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
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

1) The Director of Care (DOC), or management designate shall revise the plan of care and reassess strategies to implement when resident #004's responsive behaviors are triggered. The DOC or management designate shall provide education to all direct care staff working with resident #004 of the identified strategies.

2) The DOC or management designate shall provide education to all staff that work on the BSU on the criteria to initiate a DOS, and how to complete the DOS in its entirety.

3) The DOC or management designate shall develop and implement a process to verify that the Dementia Observation System (DOS) tool is completed in its entirety, when initiated. The DOC or management designate shall complete one audit, one time a week for four weeks, of a resident on the BSU that requires a DOS. The audit shall include the name of the person completing the audit, the date, the name of the

resident audited, and identify whether the DOS was completed in its entirety. The audit shall indicate what corrective measures were implemented if the DOS is incomplete.

4) All audits and training records shall be documented, retained, and made available to Inspectors, immediately upon request.

Grounds

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

Rationale and Summary

1) A Critical Incident Report (CIR) was submitted to the Director, related to an altercation between two residents.
A review of the resident's clinical record and progress notes indicated that their Dementia Observation System (DOS) was incomplete on several dates and times.

Additionally, no DOS was implemented to monitor the residents after their altercation.

Registered Nurse (RN) #105 and the Behavioural Support of Ontario (BSO) Personal Support Worker (PSW) #113 acknowledged that DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for residents exhibiting responsive behaviours.

RN #105, and the BSO PSW #113 indicated that a DOS monitoring tool should have been completed after an altercation between the two residents.

RN #105 and the BSO PSW #113 indicated that the DOS documentation needs to be completed to monitor a resident's responsive behavior. BSO PSW #113 and RN #105 further indicated that the registered staff would evaluate the DOS upon completion and report the findings to the Physician.

RN #105 confirmed that the DOS documentation was incomplete for multiple shifts and indicated that the residents had multiple altercations with co-residents.

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

Sources: Resident's clinical records, and interviews with staff. [741773]

Rationale and Summary

2) A CIR was submitted to the Director, related to an altercation between two residents. Resident #003 entered resident #004's personal space, which resulted in an altercation. A review of resident #004's care plan indicated that resident #004 did not like others in their personal space and exhibited responsive behaviors as a result. Clinical records for resident #004 were reviewed, and there were no interventions to prevent altercations despite their known triggers.

PSW #106 and RN #105 indicated that, resident #004 had multiple altercations towards co-residents who would enter their personal space and indicated that the care plan was missing interventions to prevent altercations between resident #004 and co-residents.
Failure to identify and implement interventions for resident #004's known triggers and patterns of responsive behavior resulted in an altercation between residents #004 and #003.

Sources: Resident #004's clinical records, and interviews with staff. [741773]

This order must be complied with by September 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.