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:** November 22, 2024

**Inspection Number:** 2024-1546-0003

**Inspection Type:**
Complaint
Critical Incident
Follow up

**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): November 4-5, 2024, November 7-8, 2024, November 12-14, 2024

The following intake(s) were inspected in this complaint inspection:

An intake related to responsive behaviour, and safety of resident
An intake related to Falls Prevention and Management
An intake related to the resident's attempt to self-harm
An intake related to resident to resident abuse
An intake related to resident to resident abuse
An intake related to follow-up of compliance order
An intake related to Falls Prevention and Management
An intake related to improper care of resident
An intake related to the outbreak.
An intake related to resident to resident abuse
An intake related to resident safety

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1546-0002 related to O. Reg. 246/22, s. 59 inspected

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Admission, Absences and Discharge

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Behaviours and altercations

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 60 (a)**
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

1. The licensee failed to implement interventions to minimize harm and risk of harm to residents and staff.

**Rationale and Summary**

A critical incident report (CIR) was submitted to the Director.

The home's Responsive Behaviour Policy directs that its program is maintained to reduce the episodes of responsive behaviour and risks for other residents and staff.

The plan of care for the resident documented a focus on eliminating and reducing the behaviours with interventions to remove access to harmful possessions.

Staff indicated that the resident had harmful possessions in their room and that the home did not want to upset the resident by removing the items from their room.

Staff acknowledged that the unsafe items in the resident's room posed a safety risk to the resident, other residents and staff of the home. As a result, the home discharged the resident from home.

Failing to implement the intervention to remove harmful possessions from the resident's room posed a risk to the residents and staff of the home.

**Sources:** Critical Incident Report, "Responsive Behaviour Prevention and Management Program" Policy # INTERD 03-09-01 Regional Municipality of Durham, revised July 2021, resident's clinical health record, interviews staff.

2. The licensee failed to develop and implement interventions to minimize harm and risk of harm from resident's responsive behaviours towards co-residents and staff.

**Rationale and Summary**

A complaint was submitted for ongoing safety concerns related to a resident's responsive behaviours, and aggression toward staff.

The home's Responsive Behaviour Policy directs that its program is maintained to reduce the episodes of responsive behaviour and risks for other residents. Furthermore, the purpose of the program includes reducing episodes of altercations and harmful interactions between and among residents, and toward staff.

Staff indicated they were aware of the residents' responsive behaviours and acknowledged that their behaviours are ongoing and interventions have been ineffective in reducing them.

Failing to reduce resident's responsive behaviours poses a risk of injury to residents and staff.

**Sources:** Complaint, "Responsive Behaviour Prevention and Management Program" Policy INTERD 03-09-01 Regional Municipality of Durham, revised July 2024, clinical records of resident, Interviews with staff.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure a complaint alleging safety concerns of resident was submitted to the Director.

**Rationale and Summary**

A Complaint was submitted to the Director related to resident's safety.

The home's Complaint policy directs that a complaint is an allegation of concerns related to the care of a resident or operation of the home and are to be forwarded to

the Director and a response provided to the complainant and the MLTC within 10 business days.

Staff acknowledged they had received a verbal complaint from the complainant about the safety of a resident, and they initiated steps to implement safety interventions.

Staff indicated they were not aware of the complaint but acknowledged the home has a complaint policy and it should have been submitted to the Ministry and responded with a letter to the Complainant.

Failing to ensure a complaint related to the safety of the resident posed a risk that the complaint was not taken seriously by the home or resolved.

**Sources:** Complaint, "Management of Complaints Policy #ADM 01-07-19 Regional Municipality of Durham, revised June 1, 2022, the clinical health records for resident, interviews with staff.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.**
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the

reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that complaints regarding the resident's care and safety were investigated and that the complainant received a response to their complaint within 10 business days of the receipt of the complaint.

**Rationale and Summary**

A complaint was submitted to the Director regarding the safety of the resident.

The home's complaint policy directs those verbal complaints that concern care or the operation of the home, that are not solved within 24 hours, will be reported to the Director and a written response provided to the complainant, with the response including the MLTC's toll free number for making complaints, its hours of operation as well as contact information for the patient ombudsman. The response shall also include an explanation of what the Home has done to resolve the issue or an explanation as to why the Home believes the complaint is unfounded, with the reasons for that belief.

Staff indicated the complainant expressed concerns to them and that they had initiated interventions to improve safety but acknowledged they had not submitted the complaint to the Director or provided a written response to the Complainant.

Failing to investigate and resolve the resident's safety concerns and provide a response to the complainant in accordance with the complaints process placed the resident at risk of harm, and their concerns remained ongoing.

**Sources:** Complaint, "Management of Complaints Policy" #ADM-01-07-19 Regional Municipality of Durham, revised June 1, 2022., resident's clinical health records, interviews with staff.

## WRITTEN NOTIFICATION: Restriction on discharge

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 156**
Restriction on discharge
s. 156. No licensee of a long-term care home shall discharge a resident from the long-term care home unless permitted or required to do so by this Regulation.

The licensee failed to ensure the resident was discharged as permitted to do so by this Regulation.

**Rationale and Summary**

A CIR was submitted to the Director.

The home discharged the resident due to safety reasons.

Staff acknowledged that they did not comply with O.Reg. 246/22 s. 161 Requirements on licensee before discharging a resident.

**Sources:** CIR, Home's investigation notes, resident's clinical health records and interviews with staff.

## WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 161 (1) (a)**
Requirements on licensee before discharging a resident
s. 161 (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or

The licensee failed to ensure that the resident received notice of discharge as far in advance of the discharge as possible.

**Rationale and Summary**

A CIR was submitted to the Director.

Staff indicated that they informed the resident verbally that they were being discharged and acknowledged that they did not provide notice of the discharge as far in advance as possible.

Failing to provide the resident with notice of discharge as far in advance as possible posed a risk that the resident would not have the accommodation, care or services they required.

**Sources:** CIR, Homes investigation notes, interview with staff

## WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 161 (2) (a)**

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

The licensee has failed to ensure that before discharging the resident under subsection 157 (1), ensure that alternatives to discharge have been considered and, where appropriate and tried.

**Rationale and Summary**

A CIR was submitted to the Director. Home discharged resident for safety reasons.

Staff indicated that they did not have time to discuss alternative options and acknowledged they immediately discharged the resident as they considered them a safety risk to the home.

Failure of the home to ensure an alternative to discharge was considered led to the discharge of the resident without other alternatives being potentially successful.

**Sources:** CIR, Resident's clinical records, interviews with staff.

## WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 161 (2) (b)**

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

The licensee has failed to ensure that before discharging the resident under subsection 157 (1), in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

**Rationale and Summary**

A CIR was submitted to the Director.

Staff indicated that before discharging the resident, they did not collaborate with the appropriate placement coordinator and other health service organizations to make alternative arrangements for the accommodation, care, and secure environment required of the resident. Staff further acknowledged that they informed the

placement coordinator following the resident's discharge. The placement coordinator's senior manager confirmed this in an interview.

The staff of the home acknowledged that the home did not make alternate arrangements for the accommodation, care, and secure environment required by the resident due to insufficient time.

Failure by the home to make alternative arrangements for the resident's accommodation, care and secure environment, in collaboration with the appropriate placement coordinator and other health service organizations, led to the resident losing their bed.

**Sources:** Resident's clinical records, interviews with staff

## WRITTEN NOTIFICATION: Requirements on licensee before discharging a resident

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 161 (2) (c)**

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

The licensee has failed to ensure that before discharging the resident under subsection 157 (1) the resident was kept informed and given an opportunity to participate in the discharge planning and that their wishes were taken into consideration.

**Rationale and Summary**

A critical incident report was submitted to the Director.

The home's policy, "Discharge Planning to the Community," directs that discharge planning is an integral part of resident care management and is a joint effort between the resident, family, and interdisciplinary team.

Staff indicated that discharging the resident was their best option as the resident posed a safety risk to residents and staff.

Staff acknowledged that before discharging the resident, the home did not give the resident an opportunity to participate in the discharge planning and that their wishes were not taken into consideration.

Failure of the home to ensure that before discharging the residents, they were given an opportunity to participate in the discharge planning and that their wishes were taken into consideration resulted in the residents losing their beds.

**Sources:** CIR, Policy "Discharge Planning to the Community, Policy # ADM-01-03-28 revised May 2022, resident's clinical records, Policy on Admission and Discharge, Interview staff.