Ontario

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

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

Central East District
33 King Street West, 4th Floor
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Original Public Report

Report Issue Date: January 3, 2023	
Inspection Number: 2022-1546-0001	
Inspection Type: Critical Incident System	
Licensee: Regional Municipality of Durham	
Long Term Care Home and City: Fairview Lodge, Whitby	
Lead Inspector Waseema Khan (741104)	**Inspector Digital Signature** Waseema Khan Digitally signed by Waseema Khan Date: 2023.01.04 12:06:59 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 19, 20, 21, 22, 2022

The following intake(s) were inspected:

- Intake: #00006708 Resident sustained significant injury of unknown cause.

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

Falls Prevention and Management
Reporting and Complaints
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (3) 4.

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The licensee failed to ensure that the Director was informed of the incident(s) that caused an injury to a resident, for which a resident was taken to a hospital and resulted in a significant change in their health status, no longer that one business day after the occurrence.

Rationale and Summary
The home submitted a CIS report to the Director for an incident that occurred involving a resident. CI Date and Time 17-Mar-2022 06:00 and CI first Submitted to MOH 21-Mar-2022 at 14:35 it was noted that after hours pager was not contacted. The CIS report indicated that the incident caused injury to a resident for which they were transferred to the hospital and resulted in a negative change in their health status. Director of Care (DOC) and Resident Care Coordinator (RCC) confirmed the CIS report was not submitted to the Director within one business day as was required and that the after-hours pager was not contacted.
Failure to notify the Director of an incident within the required period did not pose a risk to the resident's care or safety.

Sources: CIS report [CI: M522-000007-22], interview with the DOC and RCC.

[741104]