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

Toronto District
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: December 27, 2023
Inspection Number: 2023-1547-0005
Inspection Type: Critical Incident Follow up
Licensee: City of Toronto
Long Term Care Home and City: Fudger House, Toronto

Lead Inspector Oraldeen Brown (698)	**Inspector Digital Signature** Oraldeen C Brown 2024.01.08 12:58:25 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 24, 27, 28, 30, 2023
The inspection occurred offsite on the following date(s): November 29, 2023 and December 1, 5, 2023

The following intake(s) were inspected:
- Intake: #00091322 - Critical Incident (CI) M524-000013-23 related to a missing resident.
- Intake: #00097622 - Follow-up Compliance Order (CO) #001 related to Transferring and Positioning Techniques
- Intake: #00099647 – CI M524-000015-23 related to Respiratory outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1547-0004 related to O. Reg. 246/22, s. 40 inspected by Oraldeen Brown (698)

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

Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

The licensee has failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of the resident's safety risks.

Summary and Rationale
The home submitted a Critical Incident Systems (CIS) to the Ministry of Long-Term Care (MLTC) related to a missing resident.

The resident's written care plan was not updated to indicate that they had a history of elopement prior to admission to the home.

The resident left the secure home area with a Recreation Services Assistant (RSA) staff to attend an outdoor program outside in the courtyard. The resident had not returned to the secure home when the program ended and a Code Yellow was initiated.

The Programs and Services Manager (PSM) #102, Nurse Manager (NM) #104, RSAs #112 and #113, Registered Practice Nurses (RPNs) #108 and #109, all acknowledged that they were unaware of the resident's history of elopement and became aware on the day of the incident. This safety risk was not indicated in the resident's written plan of care.

Sources: Review of resident #001's clinical health records, CIS #M524-000013-23, home's investigation notes; and interviews with PSM #102, RSAs #112 and #113, and other staff.
[698]

WRITTEN NOTIFICATION: Safe and secure home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe

and secure environment for its residents.

The licensee has failed to ensure that the home was a safe and secure environment for resident #001.

Summary and Rationale
The home submitted a CIS to the MLTC related to a missing resident.

The resident was discovered and returned to the home accompanied by a Police Officer.

It was identified that the courtyard gate was left open by contractors who were working at the facility, when the resident wandered off and exited the home's property.

RSA #113 advised that they should have had more staff in the courtyard at the time of the event and should have checked to make sure that all the courtyard gates were locked prior to the activity.

PSM #102 acknowledged that the home was not safe and secure for the resident when they were able to exit through an open courtyard gate.

There was moderate risk of harm to the resident's health and safety, when the home did not ensure that the courtyard gate was locked prior to taking residents outside for an activity program.

Sources: Review of resident #001's clinical health records, CIS #M524-000013-23, home's investigation notes; and interviews with PSM #102, RSAs #112 and #113, and

other staff.
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