

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 West District

609 Kumpf Drive, Suite 105 Waterloo, ON, N2V 1K8 Telephone: (888) 432-7901

centralwestdistrict.mltc@ontario.ca

	Original Public Report
Report Issue Date: December 14, 2022	
Inspection Number: 2022-1491-0002	
Inspection Type:	
Critical Incident System	
Licensee: Fairview Mennonite Homes	
Long Term Care Home and City: Fairview Mennonite Home, Cambridge	
Lead Inspector	Inspector Digital Signature
Amanpreet Kaur Malhi (741128)	
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

December 7 - 9, 2022 and December 13, 2022

The following intake(s) were inspected:

• Intake: #00008809-2992-000018-22 related to the fall of a resident resulting in a significant change in their health status

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

Falls Prevention and Management Infection Prevention and Control



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

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

The Licensee failed to ensure that an intervention for preventing falls was applied for a resident as set out in their plan of care.

Rationale and Summary

A resident had an unwitnessed fall that resulted in a significant change in their health status. Their plan of care identified them as high risk for falls and instructed staff to implement a specific intervention to help prevent falls. During the inspection, the resident was observed without the intervention in place.

When the resident did not have their intervention in place to help prevent falls, they were at an increased risk of sustaining another fall-related injury.

Sources: CI report, Resident's observation in their wheelchair, Resident's Clinical Records, and Interview with staff

[741128]