Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 15, 2022	2022_956723_0003	002082-22, 002899-22	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Fox Ridge Care Community
389 West Street Brantford ON N3R 3V9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADELFA ROBLES (723), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 9-11, 14-16, 22, 23 and February 24, 2022.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Log #002082-22, and Log #002899-22, were related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager/Previous Infection Prevention and Control (IPAC) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), RAI-Coordinator and Personal Support Workers (PSWs).

During the course of the inspection, the inspectors observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident’s written plan of care provided clear directions to staff and others who provide direct care to the resident.

Over a period of two months, a resident had five falls; and three of the falls incidents were related to self transfer. Clinical records indicated that the resident would transfer independently. On an identified day, the resident had a fall; was sent to the hospital and returned to the home with a new medical diagnosis. Behavioral Support Ontario (BSO) electronic progress notes indicated the resident sustained an injury after attempting to self transfer.

The resident’s written plan of care indicated that the resident was at risk for falls. The written plan of care was reviewed and revised after each fall but did not indicate that the resident was at risk for falls due to self transfer.

Staff interviews confirmed that the resident was at risk for falls due to self transfer and this should have been identified in the resident’s plan of care. The ADOC confirmed that resident’s plan of care should have clearly identified that the resident was at risk for falls due to self transfer.

Not ensuring the resident's plan of care provided clear direction that the resident was at risk for falls due to self transfer, may have placed the resident at risk for further falls.

Sources: A resident’s clinical records and interviews with ADOC and other staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 18th day of March, 2022

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.