

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Sudbury Service Area Office**  
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<b>Original Public Report</b>	
<b>Report Issue Date:</b> November 17, 2022	
<b>Inspection Number:</b> 2022-1110-0001	
<b>Inspection Type:</b> Proactive Compliance Inspection	
<b>Licensee:</b> 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
<b>Long Term Care Home and City:</b> Waters Edge Care Community, North Bay	
<b>Lead Inspector</b> Jennifer Nicholls (691)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Sylvie Byrnes (627) Charlotte Scott (000695) attended the inspection during orientation.	
<b>INSPECTION SUMMARY</b>	
The Inspection occurred on the following date(s): October 24-28, October 31, and November 1-3, 2022.	
The following intake(s) were inspected: <ul style="list-style-type: none"> <li>• One Intake-PCI Inspection</li> </ul>	

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

- Infection Prevention and Control
- Prevention of Abuse and Neglect
- Residents' Rights and Choices
- Medication Management
- Falls Prevention and Management
- Pain Management
- Skin and Wound Prevention and Management
- Quality Improvement
- Residents' and Family Councils
- Food, Nutrition and Hydration

Housekeeping, Laundry and Maintenance Services  
Resident Care and Support Services

## 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 has failed to ensure that the care set out in the plan of care for a resident, was provided to a resident as specified in the plan.

#### Rationale and Summary

A resident's written plan of care identified that a resident was to have a specified intervention at specified times. During the inspection, the resident was observed two times without this specified intervention in place. The Director of Care (DOC) acknowledged that the resident's written plan of care should have been followed and was not.

There was moderate impact with this specified intervention not being applied as specified in the plan of care.

Sources: Interviews with the resident's family member, the DOC, and other staff; inspector observations; record review of the resident's current care plan, MDS admission data and the home's policy titled, "Documentation- Plan of Care", #VII-C-10.90, last revised April 2019.

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### WRITTEN NOTIFICATION: Hand Hygiene

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the hand hygiene program implemented by the home, was in accordance with the standards or protocols issued by the Director, with respect to support for residents to perform hand hygiene (HH) prior to receiving meals.

### Rationale and Summary

The IPAC Standard for LTCHs, Additional Requirement, 10.4, indicated the licensee was to ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals.

During a lunch meal service, one resident was observed being assisted by staff with HH in the dining room prior to their lunch meal service after the resident requested assistance; no other residents were assisted or encouraged to complete HH prior to their meal. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) acknowledged that residents should have been assisted with hand hygiene.

The lack of assistance for hand hygiene prior to a meal service caused a moderate risk to residents, as the home was not in outbreak at the time of the observation.

**Sources:** Observations of a home unit lunch meal service; Record review of the Home's policy titled, "Hygiene Program", #IX-G-10.10, last revised December 2021; Infection Prevention and Control Standard for Long-Term Care, April 2022. Interviews with the IPAC lead and other staff.

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

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