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
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Original Public Report

Report Issue Date: July 19, 2024	
Inspection Number: 2024-1317-0003	
Inspection Type: Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Harmony Hills Community, Toronto	
Lead Inspector Jack Shi (760)	**Inspector Digital Signature** Jia J Shi Digitally signed by Jia J Shi Date: 2024.07.19 15:46:19 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 18, 19, 2024

The following intakes were inspected:

- Intake: #00113763 & 00116526 - IL-0125126-AH/2832-000004-24 & 2832-000006-24 – both were related to an injury from an unknown cause

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that a resident's plan of care was revised when their care needs had changed.

Rationale and Summary:
The inspector observed a resident who did not have a working falls prevention intervention. The resident's care plan at that time indicated this intervention was required to be used.

A RPN confirmed the falls prevention intervention was not working at the time of the observation. The Associate Director of Care (ADOC) stated that the resident did not require the use of this intervention and the care plan should have been updated to reflect the resident's current care needs.

On the following day of the observation, this intervention was removed from both the resident's plan of care and also from their room.

Failure to ensure that a resident's falls interventions reflect their current needs may lead to unclear directions for the resident's care.

Sources: Observation in the resident's room; a resident's care plan; Interviews with the ADOC and an RPN. [760]

Date Remedy Implemented: July 19, 2024