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

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

Original Public Report

Report Issue Date: July 9, 2024
Inspection Number: 2024-1348-0003
Inspection Type: Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Stirling Heights, Cambridge

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.07.12 10:25:30 -04'00'

Additional Inspector(s)
Sarah Doepel (000858)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 25-28, 2024 and July 2-5, 2024.

The following intake(s) were inspected:

- Intake: #00115155 - 2863-000008-24 -Fall of a resident resulting in an injury
- Intake: #00118714 - 2863-000014-24 Fall of a resident resulting in Lan injury

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to ensure that staff implemented the fall and injury prevention strategies for a resident.

Rationale and Summary:

The home's fall prevention program identified that prevention strategies to reduce or mitigate falls should be in place for each resident.

A resident's falls prevention strategies were not followed when their call bell was

ringing for an extended period of time without response.

The ED said staff should have responded to the resident's call bell when they came on their shift.

Failure to respond to a resident's call for assistance put the resident at risk for harm due to unsuccessful self transfers.

Sources: CIS 2863-000014-24, plan of care, Tacera call history, home's investigation, interviews with resident and staff.

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