

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 East District

33 King Street West, 4th Floor Oshawa, ON, L1H 1A1 Telephone: (844) 231-5702

Public Report

Report Issue Date: January 30, 2025

Inspection Number: 2025-1134-0001

Inspection Type:Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Fosterbrooke, Newcastle

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20-22, 2025

The following intake(s) were inspected:

• Intake: #00135790 - 2625-000015-24 - Falls prevention and management

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

Infection Prevention and Control Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)



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 East District 33 King Street West, 4th Floor Oshawa, ON, L1H 1A1 Telephone: (844) 231-5702

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 has failed to ensure that the resident's plan of care was reviewed, revised, and updated when there was a change in the resident's care needs.

A resident experience several falls over a identified period of time. During that time, they were also hospitalized. The resident returned to the home deconditioned, the plan of care was not updated as care needs changed and there was a significant change in condition.

Physiotherapy made recommendations for a fall's prevention intervention after the second fall, and there was no indication this was considered.

Fall's interventions identified in the plan of care, did not include three specific interventions. Staff indicated resident had the two specific interventions in place at the time of the fall, but there was no confirmation of the third being used. They also indicated they would refer to the plan of care for resident care needs.

Sources: CI, Resident clinical records, interview with staffs.



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 East District

33 King Street West, 4th Floor Oshawa, ON, L1H 1A1 Telephone: (844) 231-5702