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
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: October 18, 2024
Inspection Number: 2024-1492-0004
Inspection Type: Critical Incident
Licensee: IOOF Seniors Homes Inc.
Long Term Care Home and City: IOOF Seniors Home, Barrie

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9-11, 2024

The following intake(s) were inspected:

- Intake 00118439/CI 2993-000020-24 fall of a resident.

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 has failed to ensure that the written policy for staff Falls Prevention and Management was complied with related to all staff following the residents care planned interventions for resident #001.

Rationale and Summary

In accordance with O.Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that residents' falls interventions are followed as per the plan of care.

Specifically, staff did not comply with the policy "Fall Assessment and Follow-up" dated August 2023, which was included in the licensee's Falls Prevention and Management Program.

Resident #001 was found on the floor in their room after attempting to get out of their wheelchair. At the time of the fall, the resident did not have their care planned falls intervention in place. Staff did not comply with the policy and procedure for resident #001 during the time of the fall. Specifically, care planned interventions were not followed.

Sources: The LTCH's Fall Assessment and Follow-up Policy, CIS Report, Resident #001's progress notes and care plan, Interviews with RPN #107 and DRC #101.