Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: December 27, 2023	
Inspection Number: 2023-1087-0005	
Inspection Type: Complaint Critical Incident	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fox Ridge Community, Brantford	
Lead Inspector Pauline Waldon (741071)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-15, 2023

The following intake(s) were inspected:

- Intake: #00101718 - CIS: 2570-000035-23 Related to Falls Prevention and Management
- Intake: #00101807 - Complaint related to resident care

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of care set out in the plan of care for a resident was documented.

Rationale and Summary:
The resident had a Point of Care (POC) task for a check that was to be completed every shift.

Documentation for the check was not completed for five night shifts over an eleven day period.

The Interim Director of Care (DOC) stated that Personal Support Workers (PSWs) were expected to complete documentation on the care provided, in POC, by the end of their shifts.

By failing to document the care provided, there was risk that the resident was not checked as required.

Sources: Resident's Care Plan, Progress Notes, Documentation Survey Report, and interview with the Interim DOC.

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[741071]

WRITTEN NOTIFICATION: Plan of Care: Reassessment, Revision

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (a)
Plan of care
Reassessment, revision
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

The licensee failed to include the resident's Power of Attorney (POA) Care or Substitute Decision Maker (SDM) when their plan of care was revised.

Rationale and Summary:
The resident was prescribed medication to treat a condition that was to continue indefinitely according to the consulting physician. The Nurse Practitioner (NP) at the home prescribed the medication which was discontinued after reaching the prescribed end date.

The following year, the resident required additional medication to treat the condition and the SDM questioned the home as to why the medication prescribed by the consulting physician was discontinued without their knowledge.

The resident was subsequently restarted on the medication.

The Interim DOC stated that the NP was expected to discuss the discontinuation of the medication with the POA Care or SDM and document the discussion in a

progress note but acknowledged that there was no documentation to support that this was done.

Had the plan to end the medication been discussed with the POA Care or SDM, it may not have been discontinued and the resident may not have required the additional treatment.

Sources: Resident's Progress Notes, Orders, Physician's consult note and interview with the Interim DOC.

[741071]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 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 the home's falls prevention and management program was followed.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes monitoring of residents, and that it must be complied with.

Specifically, staff did not complete the homes "Q Shift 72 Hour Post Fall Note" as required.

Rationale and Summary:
Staff stated that a Q Shift 72 Hour Post Fall Note was to be completed every shift for 72 hours after a resident fall. The note included documentation on cognition, behaviour, head injury, mobility, skin integrity and pain.

The home has nine shifts over a 72-hour period. A resident fell and was absent from the home over one of the nine shifts post fall. There were no documented Q Shift 72 Hour Post Fall Notes for six of the remaining eight shifts.

By not completing the Q Shift 72 Hour Post Fall Note every shift as required, there was risk that a change in the resident's health status post fall would go undetected.

Sources: Resident’s Progress Notes and interview with staff.

[741071]