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

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

Public Report

Report Issue Date: July 31, 2025

Inspection Number: 2025-1087-0004

Inspection Type:
Critical Incident

Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Long Term Care Home and City: Fox Ridge Community, Brantford

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 23 - 25, 28 - 31, 2025

The following intakes were inspected:

- Intake: #00150178 - CIS: 2570-000027-25 - Related to falls prevention and management
- Intake: #00151932 - CIS: 2570-000030-25 - Related to falls prevention and management

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in a resident's plan of care related to a specific intervention was followed as required when on two separate dates, the intervention was observed to not be in place.

Sources: Resident's Care Plan, observations and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure that when two residents required baseline Glasgow Coma Scales related to the initiation of Head Injury Routine monitoring under the Falls Prevention and Management Program, that the assessments were documented as required.

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 and that

it is complied with.

Sources: Residents' electronic health care records, Risk Management, Falls Prevention and Management policy, Head Injury Routine policy, Head Injury Neurological Observation Tips Sheet and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber when a medication order that was changed by the physician was not processed as required, resulting in missed doses of the medication.

Sources: Resident's Orders, Medication Administration Record (MAR), Progress Notes and interviews with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee failed to ensure that when a medication order for a resident was not processed as required, resulting in missed doses of the medication, that the medication incident was documented as required.

Sources: Resident's Orders, MAR, Progress Notes and interview with staff.