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

North District
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Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1110-0002
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Waters Edge Community, North Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 26-29, 2024

The following intake(s) were inspected:

- Two intakes, which were related to falls that resulted in an injury;
- One intake, which was a complaint related to resident care concerns; and,
- One Intake, which was a complaint related to water temperatures

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Fall 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 home's falls prevention and management program which provided for strategies to reduce or mitigate falls including the monitoring of residents, was followed for a resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidents of falls and the risk of injury and that it was complied with. Specifically, staff did not comply with the home's policy.

Rationale and Summary
A resident was observed on two separate occasions without a specified intervention in place. The resident's plan of care indicated that the intervention was to be applied during a specified time. The home's falls prevention and management policy indicated that Personal Support Workers (PSW)s were to utilize the fall prevention interventions identified on the resident's plan of care. The Director of Care (DOC) acknowledged that the resident required the intervention during that time as indicated in their care plan.

There was low risk to the resident when staff didn't implement strategies to reduce or mitigate falls as per the home's falls prevention and management program by implementing the intervention as the resident was in an area that was visible to staff.

Sources: Observations during the inspection; Interviews with a PSW, Registered staff and the DOC; a resident's current care plan for fall prevention and management; home's policy titled, "Falls Prevention and Management", #VII-G-30.10, last revised June 2024.