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
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: November 19, 2024
Inspection Number: 2024-1110-0003
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):

October 21-25, 2024.

The following intake(s) were inspected:

- Intake: related to a fall of a resident, resulting in an injury.
- Intake: related to a complaint about a resident falls, and LTCH operations.

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

Continence Care
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
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 had failed to ensure that a resident was reassessed after having fallen on specific dates, and that the plan of care was reviewed and revised at that time when, the resident's care needs changed, or care set out in the plan was no longer necessary.

Sources: Critical incident report; a complaint report; a resident's progress notes; post fall assessments; care plan; policies and interviews completed with staff.