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

Public Report

Report Issue Date: May 1, 2025
Inspection Number: 2025-1441-0003
Inspection Type: Critical Incident
Licensee: Lakeland Long Term Care Services Corporation
Long Term Care Home and City: Lakeland Long Term Care Services, Parry Sound

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28-30, 2025

The following intake(s) were inspected:

- One Intake related to a improper/incompetent care of a resident.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Substitute Decision Maker Involvement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure a resident's substitute decision maker (SDM) was promptly notified when the resident sustained a fall.

Sources: A resident's electronic health record: a review of the CI; the licensee's policies; and interviews with staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a resident was transferred using safe techniques when assisting the resident.

Sources: A resident's electronic health record: a review of the CI; the licensee's policies; and interviews with staff.

WRITTEN NOTIFICATION: Fall 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 has failed to comply with the falls program to complete a specialized assessment on a specified date as required.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program must, at a minimum, provide strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's Falls Prevention policy that stated that staff were to ensure that a specialized assessment was to be done with a change in health status.

Sources: A resident's electronic health record: a review of the CI; the licensee's policies; and interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

a)The licensee has failed to ensure that when a resident has fallen, the resident was assessed, and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI was submitted to the Director related to a resident's fall incident. The resident’s assessment record was reviewed and no post-fall assessment was identified.

Sources: A resident's electronic health record: a review of the CI; the licensee's policies; and interviews with staff.

b) The licensee has failed to ensure that when a resident fell, that a specialized assessment tool was conducted as part of the post-fall assessment.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee who was required to have a falls prevention and management program, failed to ensure this program was complied with.

A CI was submitted to the Director related to a resident's fall incident. The resident’s assessment record was reviewed and no specialized assessment tool was completed.

Sources: A resident's electronic health record: a review of the CI; the licensee's policies; and interviews with staff.

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