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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 18, 2023

Inspection Number: 2023-1342-0006

Inspection Type:
Critical Incident
Follow up

Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

Long Term Care Home and City: Burloak, Burlington

Lead Inspector	**Inspector Digital Signature**
Dianne Tone (000686)	Dianne Elizabeth Tone Digitally signed by Dianne Elizabeth Tone Date: 2023.12.19 10:59:56 -05'00'

Additional Inspector(s)
Alicia Campbell (741126)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-7, 12-13, 2023

The following intake(s) were inspected:

- Intake: #00022983 - Drug Administration
- Intake: #00095528 - Neglect of Resident
- Intake: #00097358 - Fall Prevention and Management
- Intake: #00101169/Follow-up #: 1 - High Priority CO #001 / 2023_1342_0005, FLTCA, 2021 - s. 6 (7) Duty of licensee to comply with plan, CDD Dec 1, 2023

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1342-0005 related to FLTCA, 2021, s. 6 (7) inspected by Dianne Tone (000686)

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

Resident Care and Support Services
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 (7)
Plan of care
Duty of licensee to comply with plan
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 has failed to ensure that the care set out in a plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The physician ordered staff to perform a procedure on a resident. This was not completed. In addition, there was no documentation to support that staff had contacted the physician to inform them that the order could not be completed. Four days after the order, the resident's health condition declined.

By not completing physician orders, treatment was delayed which contributed to the resident's health condition declining.

Sources: resident's progress notes and hospital notes; prescriber's order; homes internal investigation notes; interviews with PSW, RPN and DOC.

[741126]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The licensee failed to ensure that no drug was administered to a resident unless the drug has been prescribed for them.

Rational and summary:

An RPN administered the wrong medication to a resident.

As a result, the resident required additional medical interventions.

Sources: Critical Incident Report, Medication Incident Report, Resident Clinical Record, Interview with DOC and RN.
[000686]