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
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 14, 2024
Inspection Number: 2024-1329-0003
Inspection Type: Complaint Critical Incident
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: The Meadows, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 25, 29 - 31, 2024 and November 1, 4 - 8, 2024

The following intake(s) were inspected:

- Intake: #00119901 - Critical Incident (CI) #2844-000015-24 related to prevention of abuse and neglect.
- Intake: #00123080 - CI #2844-000016-24 related to infection prevention and control - outbreak.
- Intake: #00123867 - CI #2844-000020-24 related to falls prevention and management.
- Intake: #00126501 - Complaint related to transferring and positioning techniques and resident injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Critical Incident Reporting

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 115 (4) (b)
Reports re critical incidents
s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246 / 22, s. 115 (4).

The licensee has failed to inform the Director within three business days when a resident was taken to hospital with injuries.

A resident was admitted to hospital with an injury. They returned to the Long-term care home with a change in condition and treatment plan. The resident's injuries and treatment plan were confirmed by the Physiotherapist (PT) and the Medical Director (MD). The Director of Care (DOC) and the Executive Director (ED) confirmed that this

incident was not reported to the Director.

Sources: Resident's clinical records and hospital records, observation of resident and interviews with MD, PT, ED and DOC,