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
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Original Public Report

Report Issue Date: June 13, 2024	
Inspection Number: 2024-1347-0002	
Inspection Type: 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: Northridge, Oakville	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2024.06.21 09:44:34 -04'00'
Additional Inspector(s) Harshita Kaur (000846)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 28, 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00109501 - [CI] 000005-24- Fall of resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care.

One day, during an observation, a resident was wearing a falls prevention protective aid while sitting in a wheelchair in the dining room. A record review was conducted to confirm that protection aid was part of the resident's plan of care. During a review of the resident's plan of care, the protection aid was not added as an intervention for the resident.

During an interview with one staff, they stated that falls prevention protective aid was an active intervention in place for the resident and acknowledged that it was

not updated on the plan of care.

The home's failure to update the plan of care could have put the resident at risk of injury.

Remedied taken before conclusion of the inspection:
On that same day, the falls prevention protective aid was added to the plan of care.
Sources: observation, plan of care, interview with staff. [741771]

Date Remedy Implemented: May 30, 2024

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