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

Public Report

Report Issue Date: November 29, 2024

Inspection Number: 2024-1347-0004

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 21, 22, 25-27, 2024

The following Critical Incident (CI) intakes were inspected:

- Intake: #00119611 - CI 2862-000028-24 - related to improper/Incompetent treatment of a resident.
- Intake: #00120320 - CI2862-000032-24 - related to duty to protect.
- Intake: #00121272 -CI 2862-000035-24 - related to injury of unknown cause for a resident.
- Intake: #00123455 -CI 2862-000037-24 - related to falls prevention and management.
- Intake: #00125674 -CI 2862-000039-24 - related to medical emergency for a resident.

The following intakes were completed in this inspection:

- Intake: #00131036- CI 2862-000048-24 - related to falls prevention and management.

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

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

Resident Care and Support Services
Food, Nutrition and Hydration
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 (7)
Plan of care
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 the plan of care was provided to a resident as specified in their plan.

Rationale and Summary
A resident's fall interventions in their plan of care was to have a device when in a chair. The resident was observed to be seated in their wheelchair with no device which was confirmed by a Personal Support Worker (PSW).

During the observation period, a PSW located the device in the resident's room, ensured it worked properly and placed the device on the resident's wheelchair. In

addition, the home provided follow-up education on falls interventions.

Sources: Resident's care plan, observations of fall interventions and interviews with PSWs and the Executive Director (ED).

Date Remedy Implemented: November 22, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, furnishings and equipment were maintained in safe condition and in a good state of repair.

Rationale and Summary
During an observation of a resident's fall interventions, a device located on the resident's bed was not functional. This was discovered when the inspector pressed down on the device, and no sound alerted. a PSW assessed the device and determined that the controller was powerless.

During the observation period, a Registered Practical Nurse (RPN) replaced batteries and turned controller back on, the device was tested, and the alarm sounded. In addition, the home provided follow-up education on falls interventions.

Sources: Resident's care plan, resident's room observations, and interviews with PSW, RPN, and the ED.

Date Remedy Implemented: November 22, 2024