

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: December 17, 2024

Inspection Number: 2024-1167-0004

Inspection Type:Critical Incident

Licensee: Maryban Holdings Ltd.

Long Term Care Home and City: Oakwood Park Lodge, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 3-5, 2024.

The following intakes were inspected:

- Intake #00120640 Prevention of Abuse and Neglect.
- Intake #00122946 and #00128499 Infection Prevention and Control.
- Intake #00125841 Falls Prevention and Management.

The following Inspection Protocols were used during this inspection:

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



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by another resident on a specified date.

Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary

On a specified date, it was reported by staff at the home that a physical altercation had occurred between two residents and one was injured. Registered staff assessed the injured resident and initiated treatment. Staff confirmed that the resident sustained their injuries as a result of physical force used by the other resident.

Failure to protect a resident from physical abuse by another resident resulted in actual harm to the resident.

Sources: Residents' physical records, Critical Incident Report, and interview with staff.