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: October 13, 2023

Inspection Number: 2023-1355-0006

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: West Oak Village, Oakville

Lead Inspector	**Inspector Digital Signature**
Indiana Dixon (000767)	Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2023.10.13 12:56:12 -04'00'

Additional Inspector(s)
Meghan Redfearn (000765)
Training Specialist
Colleen Lewis (000719)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 27, 28, 29, 2023 and October 3, 2023

The following intake(s) were inspected:

- Intake: #00021222 - [Critical Incident (CI) #2870-000005-23] – related to Falls Prevention and Management.
- Intake: #00021968 – [CI #2870-000009-23] – related to Falls Prevention and Management.

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

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 (10) (b)

The license has failed to ensure that a resident plan of care was updated when the resident's care needs change.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Director indicating a resident had an unwitnessed fall in their bathroom. The resident was sent to hospital and diagnosed with a hip fracture.

A review of a resident care plan revealed that falls prevention interventions were not reviewed or revised until after the resident had a second unwitnessed fall.

Interviews with two members of the staffing team confirmed that the resident care plan had not been revised to reflect the fall that occurred on a specific date. The staff indicated that the resident care plan should have been revised to include specific interventions for falls prevention and management.

Failure to review and revise a resident's care plan after a fall may place a resident at risk if identified interventions are not put in place of the fall.

Sources: Care plan, and interviews with members of the staffing team.

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that an intervention was in place as specified in the resident's care plan.

Rationale and Summary
On a specified date, a resident had an incident that resulted in an injury. A review of the resident's plan of care indicated they had a similar incident occur on a later date that also resulted in an injury. The outcome from the meeting following the second incident, indicated that staff are to ensure the intervention was in place.

A review of the resident's plan of care indicated that the intervention must be in place as specified in the care plan.

Inspector observed a resident on two separate dates. There was no intervention present. On one date, a staff member confirmed the intervention was not in place and on another date, another staff member also confirmed there was no intervention in place.

Not having the intervention in place posed a moderate safety risk to the resident. On a later date, the inspector observed the intervention being in place as specified in the care plan.

Sources: Observations of resident; resident's plan of care; interviews with staff members.

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