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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Original Public Report

Report Issue Date: June 9, 2023	
Inspection Number: 2023-1342-0003	
Inspection Type: Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: Burloak, Burlington	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.06.09 16:17:02 -04'00'
Additional Inspector(s) Indiana Dixon (000767)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25-26, 29-31, 2023, June 1-2, 5-6, 2023, with May 29 and June 2, 2023 conducted off-site.

The following intake(s) were inspected:

- Intake: #00084887 – Related to Falls Prevention and Management Program.
- Intake: #00019516 – Significant injury. Etiology unknown.
- Intake: #00014793 – Physical abuse of resident by another resident.

The following intakes(s) were completed in this inspection:

- Intake: #00008980; Intake: #00011647; Intake: #00008552; Intake: #00014955; Intake: #00022155 were related to falls.

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

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

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)

The licensee has failed to protect a resident from physical abuse by another resident.

Section 2 of 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 in November 2022, a resident entered another resident's room and began to rummage through their belongings. When the resident whose room it was attempted to remove the other resident from their room, that resident kicked the other resident in the leg.

The resident sustained an injury which required treatment. The other resident was removed from the area.

There was actual physical injury done to a resident as result of the incident.

Failure to protect a resident from physical abuse by another resident, led to actual harm to a resident.

Sources: Residents' clinical records, the home's investigation notes, interviews with staff. [740738]