

**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

| <b>Original Public Report</b>   |                                    |
|---|------------------------------------|
| <b>Report Issue Date:</b> September 7, 2023                           |                                    |
| <b>Inspection Number:</b> 2023-1342-0004                              |                                    |
| <b>Inspection Type:</b><br>Critical Incident                          |                                    |
| <b>Licensee:</b> AXR Operating (National) LP, by its general partners |                                    |
| <b>Long Term Care Home and City:</b> Burloak, Burlington              |                                    |
| <b>Lead Inspector</b><br>Brittany Wood (000763)                       | <b>Inspector Digital Signature</b> |
| <b>Additional Inspector(s)</b>  |                                    |

| <b>INSPECTION SUMMARY</b>  |
|--|
| <p>The inspection occurred onsite on the follow date(s):<br/>August 21-25, 2023</p> <p>Colleen Lewis (000719) was present during this inspection.</p> <p>The following intake was inspected:<br/>Intake: #00093023/CI#2856-0000019-23 related to falls prevention and management.</p> <p>The following intake(s) were completed in this inspection:<br/>Intake: 00091015/CI#2857-000017-23 and Intake: 00093140/CI#2857-000020-23 were related to falls prevention and management.</p> |

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

- Infection Prevention and Control
- Falls Prevention and Management

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## 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 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan of care.

**Rationale and Summary**

A resident's plan of care indicated that a fall intervention was to be used. An observation was made that the falls intervention was not present.

Staff acknowledged that the fall intervention was not in place on a resident's wheelchair when the wheelchair was in use.

Failure to ensure that the fall intervention was not in place, there was risk that staff could not respond to the resident in a timely manner.

**Sources:** Resident's clinical record, observations and interviews with staff.

[000763]