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: November 2, 2023	
Inspection Number: 2023-1355-0007	
Inspection Type: Complaint 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 Lillian Akapong (741771)	**Inspector Digital Signature** Lillian M Akapong Digitally signed by Lillian M Akapong Date: 2023.11.30 13:24:20 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16, 17, 18, 19, 2023

The following intake(s) were inspected:
- Intake: #00097933 – [CI: 2870-000053-23] - Physical abuse to Resident
- Intake: #00098194 – Complaint - Concerns regarding resident Abuse and neglect by staff.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

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 for a resident was provided to the resident as specified in their plan of care.

The home's STOP approach is a process that is in place for staff to follow when caring for residents with responsive behaviors. One staff did not follow the STOP approach appropriately as specified in the resident's plan of care. In a written interview between a staff and the Director of Care (DOC), the staff responded that they did not let resident out of the room and that they did not call another staff for assistance while the resident was agitated and displaying responsive behaviors.

During an interview, the DOC acknowledged that the staff did not follow the home's policy on the STOP approach as per the resident's plan of care.

The staff not following the resident's plan of care put the resident's safety at risk.

Sources: Interview with ADOC, staff, record review, investigation notes, CI report.
[741771]

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC # 002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

The licensee has failed to comply with reporting a near miss fall incident at the time of the incident as per the falls program.

The home's falls policy requires staff to follow the falls process and report near miss falls immediately. On September 25th, 2023, a PSW, stated that a resident had a near miss fall but failed to report it during the shift. After a nurse's assessment, the resident was sent to the hospital for further assessment, which was later reported that the resident had sustained an injury.

Specifically, the staff did not follow the home's falls policy and did not comply with the home's process of reporting near miss falls as per policy direction.

During an interview, the Director of Care(DOC) acknowledged that the near miss should have been reported immediately and the PSW did not follow home's policy.

The staff not following the falls policy put the resident's safety at risk as there was a delay in the resident receiving medical treatment.

Sources: Interview with ADOC, staff, record review, investigation notes, CI report.
[741771]