

**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 15, 2024

**Inspection Number:** 2024-1342-0004

**Inspection Type:**

Complaint

**Licensee:** Axiom Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axiom Extendicare LTC II GP Inc.

**Long Term Care Home and City:** Burloak, Burlington

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4-8, 2024

The following intake(s) were inspected during this Complaint Inspection:

- Intake #00129555 related weight changes, skin and wound care, dining/snack service, dress, and palliative care.
- Intake #00129943 related to alleged neglect, administration of drugs, and reporting certain matters to Director.

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

Skin and Wound Prevention and Management  
Resident Care and Support Services  
Food, Nutrition and Hydration  
Medication Management  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Palliative Care  
Reporting and Complaints

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## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: O. Reg. 246/22, s. 272**

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health, effective April 2024, stated that Alcohol-Based Hand Rubs (ABHR) must not be expired.

### Rationale and Summary

Two expired bottles of ABHR were observed at the nursing station of one of the resident home areas not in outbreak. The Infection Prevention and Control (IPAC)

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lead was notified and immediately removed both expired bottles.

**Sources:** Observations ; Ministry of Health Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024); interview with IPAC lead.

**Date Remedy Implemented:** November 4, 2024

**WRITTEN NOTIFICATION: Administration of drugs**

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 140 (2)**

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

**Rationale and Summary**

Resident's Substitute Decision Maker (SDM) complained about a specific medication being mixed with other crushed medications and administered to the resident.

The resident's Medication Administration Record (MAR) specified a particular dosage of the medication to be given on certain days and times, with a note to shake well before administration.

Staff admitted during an interview that they mixed the medication with other crushed medications before administering them to the resident.

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Failing to administer medication as prescribed to the resident had the potential to impact the therapeutic outcome of the medication.

**Sources:** Resident's clinical health record; interview with staff.