

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

Public Report

Report Issue Date: October 9, 2025 Inspection Number: 2025-1342-0005

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: Burloak, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2-3, 6-9, 2025.

The following intake(s) were inspected:

Intake: #00154006 / CI#2857-000018-25 related to resident care and support

services.

Intake: #00157266 / CI#2857-000022-25 related to medication management.

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

Resident Care and Support Services Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the



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

use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that the home's falls prevention and management program that provided strategies to reduce or mitigate falls, was complied with.

In accordance with O. Reg. 246/22, s. 11 (1) b, the licensee was required to ensure that staff complied with the home's Post Fall Management Procedure.

Specifically, staff did not comply with completing a fall risk screen when a resident had an unwitnessed fall. Upon their return from hospital they did not have planned fall interventions implemented.

Sources: Post Fall Management Procedure (effective January 2018), resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Medication Management

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

Non-compliance with: O. Reg. 246/22, s. 123 (1)

Medication management system

s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee failed to ensure that the home's medication management program that ensures the safe handling of narcotics and controlled drugs, was complied with.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that the written policy related to narcotics and controlled drugs management was complied with.

Specifically, staff did not comply with ensuring the keys to the narcotic and controlled drugs container remained in the designated nurse's possession at all times.

Sources: LTC-Narcotics and Controlled Drugs Management Policy (effective August 2016), interviews with staff; Extendicare investigation records.



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

WRITTEN NOTIFICATION: Medication Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (4) (d)

Administration of drugs

- s. 140 (4) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
- (d) the nursing student administers the drugs under the supervision of the member of the registered nursing staff. O. Reg. 66/23, s. 28 (1).

The licensee failed to ensure a nursing student was supervised while administering medications.

Registered staff was supervising a nursing student and while completing the morning med pass, the registered staff attended to another resident. The nursing student was permitted to access, prepare and administer a controlled substance to a resident unsupervised.

Sources: Interviews with staff; Extendicare investigation records, College of Nurses of Ontario (CNO) Supervised Practice Experience Partnership Program Overview, 2025 College of Nurses of Ontario.



Ministry of Long-Term Care Long-Term Care Operations Division Long-Term Care Inspections Branch

Inspection Report Under the Fixing Long-Term Care Act, 2021

Hamilton District 119 King Street West, 11th Floor Hamilton, ON, L8P 4Y7

Telephone: (800) 461-7137