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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Public Report

Report Issue Date: March 7, 2025

Inspection Number: 2025-1355-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 28, 2025 and March 3-7, 2025

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00128865 - CI 2870-000060-24 - related to prevention of abuse and neglect.
- Intake: #00130891 - CI 2870-000062-24 - related to prevention of abuse and neglect.
- Intake: #00131259 - CI 2870-000066-24 - related to prevention of abuse and neglect.
- Intake: #00132065 - CI 2870-000072-24 - related to resident care and support services.
- Intake: #00132328 - CI 2870-000073-24 - related to Infection Prevention and Control (IPAC).
- Intake: #00132804 - CI 2870-000074-24 - related to prevention of abuse and neglect.
- Intake: #00141448 - CI 2870-000018-25 - related to resident care and support services.

The following compliant intake was inspected:

- Intake: #00132429 - Complaint with concerns related to resident care and support services.

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

Continence Care
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was upheld.

A Personal Support Worker (PSW) made humiliating remarks regarding a resident which was overheard by a co-resident.

Sources: The home's investigation notes, CI Report, interview with the Executive Director (ED).

WRITTEN NOTIFICATION: Dress

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44
Dress
s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee has failed to ensure that a resident was dressed appropriately, in keeping with the resident's preferences.

A PSW did not dress the resident appropriately, according to the resident's and family's preferences on a specified date. The PSW left the resident's clothing improperly on after providing care as a way to save time later in the shift.

Sources: home's investigation notes, interview with the Director of Care (DOC), and resident's clinical health record.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A. The licensee has failed to ensure that responsive behaviour strategies for a resident were implemented.

The resident's responsive behaviour plan of care directed staff to perform certain interventions when care was being provided.

When care was provided to the resident, a PSW failed to perform the interventions which resulted in resident being handled in a fast, abrupt manner that startled them.

Sources: the resident's clinical health record, interviews with family and the DOC, and the home's investigation notes.

B. The licensee has failed to ensure that responsive behaviour strategies for a resident were implemented.

A PSW provided care to the resident and identified the resident was exhibiting a responsive behaviour during the care. The PSW continued to provide care to resident and did not implement the responsive behaviour strategy as per their plan of care.

Sources: the clinical health record for resident, interview with DOC and Registered Practical Nurse and the home's investigation notes.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes revised September 2023, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal. Two PSW's entered a resident's room, who was in droplet precautions, and failed to apply eye protection according to the signage posted and proceeded to provide care.

Sources: observations of PSWs, a resident's care plan, and the home's Droplet Precautions Procedure policy.