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

Public Report

Report Issue Date: May 7, 2025
Inspection Number: 2025-1355-0002
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: West Oak Village, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28-30 and May 1-2, 5-7 2025.
The following intake(s) were inspected:
• Intake: #00139260 - Critical Incident (CI) 2870-000011-25/2870-000012-25 - Related to resident care and support services
• Intake: #00140549 -CI #2870-000015-25 - Related to food, nutrition, and hydration
• Intake: #00140829 - CI #2870-000017-25 - Related to falls prevention and management

The following intake were completed in this inspection:
• Intake: #00140781 - CI #2870-000016-25 - Related to falls prevention and management

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

Resident Care and Support Services
Food, Nutrition and Hydration

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: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee failed to ensure that the resident's plan of care was revised and updated when the intervention was no longer in place.

The resident's written plan of care was revised.

Sources: Resident's clinical record, interview with RPN.

Date Remedy Implemented: May 2025

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to comply with the plan of care when a hip protector was to be worn daily and was not applied to resident.

On an identified date, the resident was not wearing a hip protector, fell, and sustained a fracture

Sources: interviews with staff, LTCH's investigation notes, resident #003's clinical records, Critical Incident (CI) #2870-000017-25.

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

The licensee failed to ensure that responsive behavior strategies for resident were implemented.

On an identified date, Resident exhibited responsive behaviors and showed visible signs of resistance and distress during care. Staff continued to provide care, contrary to the Stop and Go protocol, which instructs staff to pause or discontinue care when a resident is resistive.

Sources: Resident's clinical notes, CI #2870-000011-25/2870-000012-25 and interviews with staff.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (b)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(b) the identification of any risks related to nutritional care and dietary services and hydration;

The licensee failed to identify risks related to nutritional care and dietary services concerning resident's food allergy.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee was required to ensure that the nutritional care and hydration program policies and procedures were complied with.

Specifically, staff did not comply with the 'Meal Service with Technology' policy. On

an identified date, the resident, who had a food allergy, was served a food item to which they were allergic. Staff confirmed that they did not review the Meal Suite Touch app and follow the process prior to serving the resident.

Sources: Resident's Clinical record, CI #2870-000015-25, Meal Service with Technology, Interview with Dietary Aide and Executive Director.