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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: March 25, 2025
Inspection Number: 2025-1056-0002
Inspection Type: Critical Incident Follow up
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: The Willows Estate Nursing Home, Aurora

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 20, 21, 24, 25, 2025

The following intake(s) were inspected:

- One intake related to Follow-up #1: CO #001/2024-1056-0003, FLTCA, 2021 - s. 19 (2) (a), Accommodation Services,
- One intake related to Follow-up #1: CO #001/2024-1056-0005, O. Reg. 246/22 - s. 55 (2) (b) (iv), Skin and wound care, and
- One intake related to an outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1056-0003 related to FLTCA, 2021, s. 19 (2) (a)
Order #001 from Inspection #2024-1056-0005 related to O. Reg. 246/22, s. 55 (2) (b)

(iv)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance Services

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee had failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

During the initial tour, it was identified that a home-owned transfer wheelchair had duct tape on both arms, and four dining stools that staff use when assisting residents during meals were torn.

The Environmental Services Manager (ESM) confirmed that the equipment identified above was owned by the home and in need of repair.

Sources: Observations, record review, and interviews with the Environmental Service Manager, and other staff. [647]

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