

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: August 26, 2025

Inspection Number: 2025-1355-0005

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: West Oak Village, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 11-13, 19-22 & 25, 2025.

The following intake(s) were inspected:

- Intake: #00150958 - e-Correspondence - 245-2025-1569 -Complainant with concerns regarding safe and secure home.
- PC-2025-0000589 - Complainant with concerns regarding safe and secure home.

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

Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

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

Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

1. A resident who is missing for less than three hours and who returns to the home with

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

no injury or adverse change in condition.

The licensee has failed to ensure that the Director was informed of an incident involving a resident who was missing for less than three hours and returned to the home without injury or any adverse change in condition no later than one business day after the occurrence of the incident. The resident was confirmed missing by Director of Care (DOC).

Sources: Resident's progress notes and interviews with staff.

WRITTEN NOTIFICATION: Emergency plans

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

Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. viii.

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,
viii. situations involving a missing resident,

The licensee has failed to comply with the home's emergency plans when the home's Code Yellow- Missing Resident policy was not followed when the resident was missing on an identified date. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for Emergency Planning and Management were complied with. Specifically, the home's Code yellow- missing resident policy indicated that the code yellow is announced when a resident is identified as missing, which did not occur the resident.

Sources: Code Yellow- Missing Resident Policy and Interviews with staff.