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:** April 17, 2025

**Inspection Number:** 2025-1379-0002

**Inspection Type:**
Complaint
Critical Incident
Follow up

**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:** Bay Ridges, Pickering

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7 - 8, 2025, and April 11 - 17, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
An intake related to an outbreak.
An intake related to an outbreak.
An intake related to a resident's fall.
An intake related to the improper care of a resident.
An intake related to the improper care of a resident.
An intake related to the improper care of a resident.

The following intake(s) were inspected in this complaint inspection:
An intake related to neglect of a resident.
An intake related to toileting and transfers of residents.

The following intake were inspected in this Follow-up (FU) inspection:
An intake related to the Residents' Bill of Rights

The following intake was completed in this inspection:
An intake related to a resident's fall.
An intake related to a resident's fall.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1379-0001 related to FLTCA, 2021, s. 3 (1) 5.

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

Continence Care
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

NC #001 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 has failed to ensure that the care set out in the plan of care was provided as specified. Specifically, the assessment is not completed following staff referrals after a resident falls.

**Source**: Resident's health record and interview with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (1) 1.**
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
1. Treatments and interventions to promote continence.

The licensee has failed to ensure that staff complied with the home's Continence Care – Change of Continence policy.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies and protocols that were developed for the continence care and bowel management program were complied with.

Specifically, the home's Continence Care – Change of Continence policy indicated staff initiate a Continence Assessment when there is a change in continence status, which did not occur for residents.

**Source**: The home's Continence Care – Change of Continence policy, resident's health record, and interview with staff.

## WRITTEN NOTIFICATION: Continence care and bowel

## management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that an individualized plan to promote and manage bowel and bladder continence based on the assessment was implemented. Specifically, staff did not follow the care plan; instead, they changed the resident's briefs in bed.

**Source**: Resident's care plan and interviews with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee has failed to ensure that residents, received the necessary assistance from staff to manage and maintain their continence. Specifically, staff stopped assisting residents for toileting and support continence care.

**Source**: Resident's care plan and interviews with staff.

## WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 56 (2) (e)**
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

The licensee has failed to ensure that continence care products were not used as an alternative to providing toileting assistance to a resident. Specifically, staff stopped transferring the resident to the toilet to support continence care and instead changed their briefs in bed.

**Source**: Interviews with staff

## WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)**
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to ensure the implementation of dietary restrictions for

residents when a peanut butter sandwich was served to them.

Dietary Services changed the snack menu. The staff served peanut butter sandwiches to multiple residents, and their care plans indicate that they have a peanut allergy.

**Source:** Resident's care plan, and Interview with staff.

## WRITTEN NOTIFICATION: Food production

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)**
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The Licensee failed to communicate the menu substitution to residents and the unit staff.

The food services staff changed the evening snack menu for the unit. The food service department failed to label the snack or notify the unit staff or residents about this change. At the time of the incident, there was no established process at the home to communicate menu substitutions or changes to residents and staff.

**Source:** Critical Incident reports, and Interview with staff.

## WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 140 (1)**
Administration of drugs

s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The home failed to ensure that no drug was administered unless the drug was prescribed to the resident.

A Critical Incident report was submitted to the Ministry of Long-Term Care in which staff mistakenly administered another resident's medication to a resident. The staff failed to follow the necessary checks during medication administration.

**Sources:** Medication incident form, interview with staff.

**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