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: June 25, 2025

Inspection Number: 2025-1379-0003

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: Bay Ridges, Pickering

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 10 - 11, 13, 16, 18 - 20, 24 - 25, 2025.

The following intakes were inspected:
- An intake and a Critical Incident (CI) related to improper resident care.

- Two intakes and a CI related to improper resident care.

- An intake and a CI related to fracture of unknown cause.

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

Resident Care and Support Services
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements for programs.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee shall ensure that any actions taken with respect to the resident under the pain management program, including assessments, were documented.

1. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the pain management program to identify and manage residents in pain was complied with. Specifically, the registered staff did not complete the required assessment tool as directed by the home's pain assessment and management policy when the resident had received an intervention on multiple days.

Sources: Critical Incident Report (CIR), the resident's electronic health records, and physical chart, home's policy on pain assessment and management, and interview with the Director of Care (DOC).

2. The licensee shall ensure that any actions taken with respect to the resident under the pain management program, including assessments, were documented. A resident had returned from a local medical facility and had an order to complete an assessment tool. When reviewed, the tool was not fully completed with resident's responses and assessment information.

Sources: CIR, the resident's chart and electronic health records, and interview with the DOC.

COMPLIANCE ORDER CO #001 Plan of care.

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The home is to develop and implement a policy and procedure for registered staff in relation to their

subsequent follow-up actions with the service provider requisitions.

2a. The home is to provide in-person training to all active registered staff on the new policy and procedure, and to administer a test to each staff to ensure their understanding of the content.

b. The new policy and procedure is to be incorporated into the orientation training program for newly hired registered staff, and the annual re-training of all registered staff.

3. Registered management staff or registered delegated staff is to conduct a daily audit of the service provider requisitions (all Resident Home Areas) for two consecutive weeks. Home is to ensure completed audit records, including corrective actions, are available.

4. Maintain documentation of the training contents, training tests, training attendance records, and any corrective actions implemented, and make them available to inspectors upon request.

Grounds

The licensee has failed to ensure that the registered staff and the service provider involved in the different aspects of care of the resident implemented the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A CIR was submitted to the Director indicating the resident had sustained an injury not linked to an incident.

A review of the resident's electronic health records indicated that they had experienced a condition that warranted further examination and assessment. A diagnostic test was ordered and the requisition was sent to the service provider on an identified date. No staff from the long-term care (LTC) had followed up with the service provider and the diagnostic test was never provided to the resident. Days later, the resident's condition worsened and had to be sent to a local medical facility for care and treatment.

The Director of Care (DOC) asserted that the registered staff were to collaborate and communicate with the service provider for service delivery, and to document their follow-up actions in the resident's electronic health record system. The DOC further commented that they were unable to determine if the service provider had received the diagnostic requisition.

There was a high risk and impact to the resident as they did not receive their required intervention in a timely manner due to a lack of collaboration with the service provider.

Sources: CIR, the resident's physical chart and electronic health records, home's internal investigative notes, and interview with the DOC.

This order must be complied with by August 7, 2025

COMPLIANCE ORDER CO #002 Plan of care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The home will complete a Root Cause Analysis (RCA) of the resident's incident that includes multidisciplinary involvement of managers, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW). The home will keep a documented record of the RCA, the date the RCA was completed and who participated. This document will be kept and made available to the inspector upon request.

2.The home will analyze the results of the RCA and identify any deficits, inconsistencies and gaps.

3.If any deficits, inconsistencies or gaps have been identified with part #2 of the order, the home will provide education to all nursing staff to support these findings. The home shall keep a documented record of the date, who provided the education, the content of the education, and staff names and signatures. This document will be made available to the inspector upon request.

4.Re-evaluate and update any policies, procedures, protocols and training related to resident care plans, safe patient handling, and monitoring in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds

The licensee failed to ensure that the resident received care according to their care plan.

As per the resident's plan of care, the resident was to require two staff's assistance for being repositioned on a surface.

On an identified date, the Registered Practical Nurse (RPN) had completed a treatment on the resident and then repositioned the resident by self. The resident then resulted on a different surface and experienced a significant change in health condition.

When interviewed, the RPN and the DOC acknowledged the gap. The DOC further stated that the resident would not have been on a different surface should the resident was assisted by two staff members as per their plan of care.

Sources: CIR, the resident's care records, home's investigation file, interviews with the RPN and DOC.

This order must be complied with by August 7, 2025

COMPLIANCE ORDER CO #003 Training.

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The home is to review, analyze, and evaluate the current processes to ensure the contracted Footcare Nurse receives their annual retraining in infection prevention and control.

2. Maintain documentation of the review, analysis, and evaluation of the home's processes, and make them available to inspectors upon request.

Grounds

The licensee has failed to ensure that the Footcare Nurse who received training under subsection (2) received retraining in infection prevention and control (IPAC) on an annual basis. The Footcare Nurse did not receive their annual IPAC retraining in 2022, 2023, and 2024.

Sources: CIR, home's Footcare Nurse records, and interview with the Executive Director (ED).

This order must be complied with by August 7, 2025

COMPLIANCE ORDER CO #004 Infection prevention and control program.

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The IPAC Lead or designate shall ensure that all staff responsible for cleaning and reprocessing of shared footcare devices and equipment are trained in-person. The education must include:
a. The principles of cleaning, disinfection, and sterilization.
b. Spaulding's Classification.
c. The classification of equipment (critical, semi-critical, non-critical).
d. Manufacturer's instructions for use (MIFUs).
e. Provincial Infectious Diseases Advisory Committee (PIDAC) best practices for reprocessing.

2. To administer a one-time test after the education to ensure staff's understanding.

3. Maintain documentation of the training (e.g., name of the trainer(s), date and time of training, names of trainees, training contents, test results), and make them available to inspectors upon request.

Grounds

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

The licensee has failed to ensure that Additional Requirement Under the Standard was followed by staff in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022", revised September 2023.

Specifically, the Footcare Nurse did not adhere to the reprocessing of medical equipment both offsite and onsite as required by 5.4 (b) under the IPAC Standard.

A CIR was submitted to the Director indicating that the Footcare Nurse had provided improper care to the long-term care (LTC) residents.

As per the home's record, the Footcare Nurse had been providing footcare to residents on a regular basis in 2025. A review of the home's policy and procedure on cleaning and disinfection stated that medical devices and equipment were not to be used on residents if they were not reprocessed correctly between uses. When reviewing the home's internal investigative notes, the Footcare Nurse had completed the Medical Devices and Equipment Reprocessing Checklist, where the staff indicated that footcare instruments were soaked in Oxivir. The staff had also checked off not applicable or not reviewed for the sterilization section of the Checklist. The Footcare Nurse was then interviewed by the Executive Director (ED) and confirmed that re-usable footcare instruments were not sterilized after each use. The Footcare Nurse was immediately suspended from providing services in the home and was later reported to the College of Nurses of Ontario (CNO). In addition, the home had contacted Durham Public Health (DPH) for their directions.

Upon inspected by DPH, an Order of Public Health Inspector to the Footcare Nurse was served.

An interview with the DPH Inspector, the Senior Public Health Inspector, and the ED had confirmed the same. The ED further stated that the Footcare Nurse did not comply with the home's policy on proper reprocessing of footcare instrument and had terminated their footcare service.

There were potential risks and impacts to the residents for contracting bloodborne infections when re-usable footcare equipment were not properly reprocessed after each use.

Sources: CIR, home's internal investigative notes, and interviews with DPH Public Health Inspector, DPH Senior Public Health Inspector, and the ED.

This order must be complied with by August 7, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.