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: August 14, 2025
Inspection Number: 2025-1379-0004
Inspection Type:
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): August 11 - 14, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
An intake regarding the fall of a resident.

The following intake(s) were inspected in this Follow-up (FU) inspection:
Follow-up intake regarding the compliance order for Collaboration with Auxiliary Services.
Follow-up intake regarding the compliance order of the Plan of Care
Follow-up intake regarding the compliance order for Retraining.
Follow-up intake regarding the compliance order for Infection Prevention and Control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1379-0003 related to FLTCA, 2021, s. 6 (4) (b)
Order #002 from Inspection #2025-1379-0003 related to FLTCA, 2021, s. 6 (7)
Order #003 from Inspection #2025-1379-0003 related to FLTCA, 2021, s. 82 (4)
Order #004 from Inspection #2025-1379-0003 related to O. Reg. 246/22, s. 102 (2) (b)

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

Resident Care and Support Services

Infection Prevention and Control
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure that staff collaborated to develop and update the plan of care when a resident's mobility needs changed. The resident's clinical record states that the resident needed alternative assistance for mobility; however, the plan of care was not revised to reflect this change. Consequently, the resident experienced a fall, which increased the risk of harm.

Sources: Clinical Records of the resident, and Interviews with staff

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