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: October 6, 2025
Inspection Number: 2025-1379-0005
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): September 23 - 26, 29, 2025, and October 1 - 3, 6, 2025.

The following intake(s) were inspected:

- Two intakes were related to improper care of a resident.
- One intake was related to an unwitnessed fall of a resident.
- One intake was related to a complaint regarding the unexpected death of a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an alleged care concern regarding a resident was reported immediately to the Director.

The home was required to submit a Critical Incident Report (CIR) to the Ministry of Long-Term Care (MLTC), when the home received notification from an individual regarding multiple care concerns for a resident. The Executive Director (ED) acknowledged the home failed to submit the CIR immediately.

Sources: CIRs, eCorrespondence, LTCH investigation notes, resident's clinical records, interviews with Police, and ED.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the home's falls prevention and management program when a resident's assessed falls risk and interventions were not included in their individualized care plan upon admission. In accordance with Ontario Regulation (O. Reg.) 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with. Specifically, the home's falls policy indicated that upon move-in, a resident's fall risk status, including risk factors, would be assessed to support the development of an individualized plan of care.

On admission a resident was assessed to have a risk for falls and interventions were recommended. The recommended interventions and associated risk were not updated in the resident's care plan and Kardex until after they experienced an incident. The Assistant Director of Care (ADOC) acknowledged that this information was not available to staff prior to the incident and was important for the staff to know for resident safety.

Sources: Resident's clinical record, the home's policy Fall Prevention and Injury Reduction Procedure, and interview with the ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to immediately report the unexpected death of a resident to the Director after it occurred on a specified date, as confirmed by the ADOC. The incident was reported in a Critical Incident Report ten days after.

Sources: CIR, resident's clinical record and interview with the ADOC.

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