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: January 20, 2026
Inspection Number: 2026-1379-0001
Inspection Type: 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): January 6 - 9, 12- 14 & 19, 2026

The inspection occurred offsite on the following date(s): January 15 & 16, 2026

The following intake(s) were inspected:
- Two intakes related to allegations of improper care.
- Two intakes related to allegations abuse.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

A resident's rights to freedom from abuse was not fully respected and promoted on a specified date when staff was verbally abusive during care.

Sources: Critical Incident Reports (CIR), home's investigation notes, a resident clinical records, Zero Tolerance of Abuse and Neglect Policy, Types and Definitions of Abuse and Neglect policy, and interviews with staff

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

A resident's plan of care was not reviewed and revised when their specified medical health condition changed.

Sources: Resident clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specified date staff did not ensure a resident safety when the resident slipped out of the hoyer lift resulting in a witnessed fall sustaining an injury. Improper/incompetent care of the resident was substantiated and confirmed by the home.

Sources: Resident clinical records, CIR; home's investigation file, Safe Resident Handling Procedure, Lift and Transfer Devices Procedure, 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 (1) 2.

Continence care and bowel management

s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:

2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.

Treatments and interventions were not provided for a specified health management of a resident to manage their care needs. Specifically, staff did not provide the resident with their specified protocol.

Sources: Resident clinical health records and interviews with staff

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)

Nutritional care and hydration programs

s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

The home did not monitor and evaluate a resident's nutrition and hydration status when they did not complete the hydration assessments and dietary referrals when the resident was identified to have a risk related to nutrition and hydration.

Sources: Resident clinical health records, Nutrition and Hydration Policy, home's hydration monitoring process and interviews with staff

COMPLIANCE ORDER CO #001 Integration of Assessments, care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
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,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee is ordered to:
1. Review the following protocols and communicate them to ensure staff have a clear understanding so they work together consistently:
a.) Hydration monitoring and assessment
b.) Reporting, documentation and escalation of abnormal and critical laboratory results
c.) Bowel management protocols, including integration with hydration and clinical status
Staff are to include nursing staff, Registered Dietitian and interdisciplinary staff involved in the completion or follow up of these protocols.

2.. Conduct a weekly audit for four consecutive weeks to evaluate compliance with:
a.) Documentation and reporting of abnormal and critical laboratory results
b.) Hydration monitoring and assessment
c.) Dietary referrals initiated due to low intake or clinical alerts
d.) Implementation of bowel management protocols
The audits should identify any gaps in compliance, corrective actions taken and staff re-education where required.

3. Maintain documentation of the communication provided to staff and others related to protocols and the completed audits.

Grounds

Staff and others did not collaborate to ensure that assessments related to a resident's nutrition, hydration, bowel management, laboratory results, and overall condition were integrated, consistent, and completed in a timely and coordinated manner.

On a specified date, a laboratory communicated an abnormal result to a nurse on the night shift; however, the notification was not acted upon, documented, or communicated to the physician. The resident was transferred to hospital on a specified date, when the abnormal result was later identified by another member of the nursing staff. The

resident subsequently passed away in hospital.

Between specified dates, the resident experienced significant changes in condition, including documented weight loss greater than 5%, reduced oral intake, swallowing difficulties, skin breakdown, and altered bowel patterns.

Hydration records from specified dates consistently demonstrated that the resident fluid intake was below the minimum fluid goal set by the Registered Dietitian (RD). Staff indicated that night and day nursing staff are expected to collaborate to monitor fluids, complete hydration assessments, and refer to the dietitian each time a resident has less than the minimum fluid intake for three consecutive days. The RD acknowledged they did not receive any dietary referrals from nursing staff related to hydration monitoring results showing consistently low intake.

Clinical records reviewed demonstrated that a resident had a bowel management protocol in place that was not implemented as ordered. During this same period, hydration monitoring showed that a resident fluid intake was consistently less than their minimum requirements. Despite this, routine bowel management interventions, continued to be administered. There was no evidence that hydration status was considered when bowel interventions were administered, nor that bowel management orders were reviewed or adjusted in response to sustained low fluid intake.

There was also no evidence of collaboration with the nurse practitioner or physician to communicate a resident declining hydration and nutrition status, or to review medication orders for appropriateness.

During interviews, the staff acknowledged that the lack of coordinated review of hydration status, bowel management interventions, and delayed laboratory result follow up posed a risk to a resident.

This finding is supported by and linked to secondary findings under:

• O. Reg. 246/22, s. 74 (2) (e) – lack of an effective system for monitoring nutrition and hydration; and
• O. Reg. 246/22, s. 56 (1), (2) – lack of measures to prevent constipation, including the integration of nutrition and hydration protocols.

Staff indicated that the home had completed an investigation into the delayed receipt of abnormal results and acknowledged that staff did not document, assess a resident, or call the physician for direction on a specified date. Staff acknowledged that there was a delay of three days in acting upon the abnormal results.

As a result of staff delaying action on abnormal results and not collaborating with one another and with other disciplines in assessing a resident's clinical status, critical information was not communicated across disciplines, and changes in condition were not acted upon in an integrated and consistent manner. This resulted in a delay in recognizing and responding to a resident clinical decline, and a resident was subsequently transferred to hospital.

Sources: CIR, resident clinical health records, home’s investigation notes, home’s hydration monitoring protocol and interviews with staff

This order must be complied with by March 19, 2026

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.