

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 1, 2026
Inspection Number: 2026-1379-0002
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): March 23 -31 2026 and April 1, 2026

The inspection occurred offsite on the following date(s): March 30, 2026

The following intake(s) were inspected:

- An intake related to verbal abuse
- A follow-up intake with a due date of March 19, 2026
- Three intakes related to related to neglect
- An intake related to injury of unknown origin
- Complaint related to neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2026-1379-0001 related to FLTCA, 2021, s. 6 (4) (a).

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

Resident Care and Support Services
Prevention of Abuse and Neglect

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.

A series of miscommunications and unclear expectations regarding cross unit assistance, resulted in missed required resident care.

Sources: Clinical documentation, Interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Section 7 of the Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

A resident was not protected from neglect, when two PSWs declined to attend a neighbouring unit, and required care was not provided as planned.

Sources: Resident clinical documentations, Interview with staff.

WRITTEN NOTIFICATION: Nursing and personal support services

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

Non-compliance with: O. Reg. 246/22, s. 35 (3) (a)

Nursing and personal support services

s. 35 (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

Staffing mix in a unit was not consistent with a residents' assessed care needs; as a result, a resident required care was not provided as planned.

Sources: Resident clinical documentation, Interview with staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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