

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: August 14, 2025

Inspection Number: 2025-1341-0005

Inspection Type:

Complaint
Critical Incident

Licensee: Axiom Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axiom Extendicare LTC II GP Inc.

Long Term Care Home and City: Columbia Forest, Waterloo

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 5-8, and 11-14, 2025.

The following intakes were inspected:

- Intake 00149442 - An infectious illness outbreak.
- Intake 00150867 - A complaint related to dietary services and medication.
- Intake 00151150 - A complaint related to dietary services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

INSPECTION RESULTS

WRITTEN NOTIFICATION: Menu planning

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 77 (7)

Menu planning

s. 77 (7) The licensee shall ensure that meals and snacks are served at times agreed upon by the Residents' Council and the Administrator or the Administrator's designate. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure lunch was served on at the agreed upon time of 1200 hours on a date of the inspection.

Sources: Inspector observation on August 8, 2025, Meal Service Timing record, etc.

WRITTEN NOTIFICATION: Housekeeping

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

Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

surfaces and wall surfaces, and

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures were implemented for cleaning of resident washrooms.

In accordance with Ontario Regulation 246/22, s. 11(1)(b), the licensee was required to ensure written policies for the home's housekeeping program were complied with. Specifically, housekeeping staff were identified to not comply with the home's written procedures for cleaning washrooms, when four Schneider unit washrooms used by residents were identified within the inspection to have not been cleaned daily.

On a August 8, 2025, a public dining room washroom was noted to have dead insect bodies and spider web on the floor, as well as a discoloured toilet bowl, despite a housekeeping staff signing off on daily cleaning of the washroom since August 4, 2025. The housekeeping staff was reported to have been re-educated on cleaning resident washrooms.

Two resident washrooms were noted to have the same debris between observations on August 8, 2025 and August 11, 2025. The Environmental Services Manager noted these surfaces should have been cleaned daily in accordance with the home's cleaning policies and procedures. Housekeeping staff, including the staff member who had been re-educated, were working between August 8, 2025 and August 11, 2025 on the unit.

Sources: Inspector observations on August 8, and 11, 2025, Housekeeping Services Policy for Staff Daily Cleaning Routines, Interviews with staff etc.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

COMPLIANCE ORDER CO #001 Menu planning

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 77 (5)

Menu planning

s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246/22, s. 77 (5) [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

- 1) Review and revision as needed of the home's process for monitoring food shortage and overages to support menu planning and food production, including forecasting and ordering of food supplies.
 - (A) Ensure a written record is maintained of the finalized process.
 - (B) Ensure the record includes defined staff roles and responsibilities, and how staff will be educated on their responsibilities.
- 2) An auditing process for the established procedure, and for monitoring planned menu items are available and offered at meal services.

A written plan for achieving compliance is required to be submitted to an Inspector from the Ministry of Long Term Care by September 5, 2025.

Grounds

The licensee failed to ensure that the planned menu items were offered and

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

available at each meal.

A complaint was received by the Director regarding meal service. During the inspection, residents, as well as nursing and dietary staff, likewise reported ongoing challenges with insufficient amounts of menu items at meal services, and reduced meal portions on multiple occasions over a period of three to four months prior. The following were identified during the inspection:

1) A complainant stated the home had inadequate supply of a menu item for lunch on a specified date. A personal service worker (PSW) stated they did not have enough of the meal item during that lunch, and had to serve the residents half of a recommended portion.

Sources: Review of the weekly menu, Interviews with staff and a complainant.

2) A staff member stated the posted menu for Tuesday August 5th, 2025 was Fried Chicken, but they received an inadequate amount of chicken for all the residents in specific home area. This resulted in the staff having to cut up the chicken into smaller pieces to serve to residents. A cook confirmed that they did not have enough of the fried chicken to send up to home areas on Tuesday August 5th, 2025, and that this happens often.

Sources: Review of the weekly menu, Interviews with staff

3) Dietary staff members described having insufficient fruit at breakfast services.

On August 8, 2025, a dietary staff described having to serve two pieces of papaya to residents instead of four or five because of insufficient supply. They further reported serving applesauce for residents with therapeutic textures instead of minced and

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

pureed papaya, as per the planned menu.

Between June 8, 2025 and August 2, 2025, multiple occasions were identified where breakfast service was short of fruit, including seventeen separate dates on one unit when they were short two to seven servings of fruit.

Sources: Interviews with staff, Meal Service Overage and Shortage forms between June 2, 2025 to August 2025

4) A staff member stated the posted menu was not often what was served, particularly for cake desserts. A resident reported they would often not know what was being served until it was provided during meal service.

On August 8, 2025, the home's planned menu included a toffee cake option for lunch dessert, and a chocolate mousse option for dinner dessert.

Chocolate mousse was served at lunch instead of dinner due to an inventory management mistake.

During lunch observations on August 8, 2025 in the Breithaupt unit, residents with a puree texture modification were served chocolate mousse dessert instead of the planned menu starch option. The puree texture dessert observed for the lunch service was chocolate mousse.

Sources: Inspector observations on August 8, 2025, pureed therapeutic texture menu for August 8, 2025, Menu substitution record for August 2025

When there were insufficient quantities at meal service, staff were expected to notify foodservice management to support menu review, and ordering of food

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

supplies. The notification would be done verbally, or documented on meal service shortage forms.

Multiple entries were blank on meal service shortage forms reviewed between June 2025 and August 2025. Furthermore, staff described different expectations for completion of the shortage forms, and the District Foodservice Manager noted there was no formal written procedure.

Members of management expressed they were not aware of concerns with insufficient menu options involving portion sharing until late July 2025.

Residents expressed disappointment with not receiving a meal as per the posted menu.

When planned menu items were not offered at meal service, or provided in planned portions on multiple occasions, residents' quality of life was at greater risk of being negatively impacted.

Sources: Interviews with a complainant, as well as multiple staff, etc.

This order must be complied with by October 31, 2025

COMPLIANCE ORDER CO #002 Food production

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

Food production

s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78
(3).

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall:

1) Train all Dietary Aide staff on the licensee's procedures for monitoring food temperatures at meal service, including when and how to take corrective action, as well as associated documentation. Maintain written records of the following:

- (A) Training content, including the provider, as well as date(s) and format provided
- (B) Staff signatures of attendance at the training, including date(s) of attendance
- (C) List of Dietary Aide staff

2) Following the training completion, conduct the following:

(A) Daily audits of temperature logs for all meals on all home areas over a two week period. Maintain a record of the audits, including:

- (I) Who completed the audit, as well as the time and date of audit completion
- (II) Whether deficiencies were identified, including the nature of the deficiency as well as which staff name and home area, and what corrective action was taken, including date and time(s) of the corrective action(s), as well as the person responsible

(B) Daily real time dining audits of meal temperatures across a two week period. Ensure the audits are conducted on at least one meal daily, including weekends, across all meals of the home. Ensure they are conducted at least once on each of the six serveries. Ensure the records include:

- (I) Who completed the audit, the time and date of audit completion, as well as the meal services and home areas reviewed
- (II) Whether deficiencies were identified, including the nature of the deficiency, as

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

well as staff name and home area, and what corrective action was taken, including date and time(s) of the corrective action(s)

Meal services reviewed in the part 2) (B) real time dining audits do not need to be included in temperature log audits from part 2)(A).

Grounds

The licensee failed to ensure that foods in the food production system are stored, and served using methods to prevent contamination and food borne illness.

1) A staff member reported occasionally, when there was not enough food available, show plates were served to residents. A cook stated that the show plates were prepared in the kitchen, and could sit at room temperature for several hours before meal service. They indicated that these plates were not to be served to residents, as doing so could increase the risk of food-borne illness.

Sources: Interviews with staff, etc.

2) In response to a complaint regarding chicken meal temperatures, a review of relevant food temperature logs from June 2025 identified chicken entrees on June 12, 19, and 25 being served at temperatures outside of safe ranges directed by the home's policy, which included under 4C for cold foods, and over 60C for hot foods. At the time of inspection, a dietary aide reported only taking action when cold food temperatures were above 12C. At least 67 temperature entries were missing from reviewed chicken entrees in June 2025.

Residents were at increased risk when the home's procedures for preventing food borne illness at meal service were not followed.

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105

Waterloo, ON, N2V 1K8

Telephone: (888) 432-7901

Sources: Interviews with staff, Temperature logs from all units in June 2025 on relevant dates, Meal Production Policy (ID CARE17-O20.02) Procedure: Food Temperature Checklist (Last reviewed March 31, 2025)

This order must be complied with by October 10, 2025

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

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

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

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:

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

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.