

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: September 10, 2025

Inspection Number: 2025-1354-0005

Inspection Type:
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: Elginwood, Richmond Hill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 8, 9, 10, 2025.

The following intake(s) were inspected:

- One intake related to an allegation of improper/incompetent care during transfers.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning techniques

NC #001 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.

The licensee failed to ensure that staff used safe transferring techniques for a resident.

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A Critical Incident Report (CIR) was submitted by the home to indicate a concern that two Personal Support Workers did not consistently assist an identified resident safely.

The plan of care for the resident, and interviews with nursing staff all indicated that the resident required a higher level of assistance.

The PSW's confirmed that they had offered the resident a lower level of assistance despite being aware of the resident needs.

Sources: CIS, resident's progress notes, POC documentation, plan of care, eMAR and interviews with resident, Director of Care, and other staff.



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

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