

Ministry of Long-Term Care

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

Hamilton District

119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: September 2, 2025

Inspection Number: 2025-1329-0003

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: The Meadows, Ancaster

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 26-29, 2025.

The following intakes were inspected:

- Intake #00151677 was related to falls prevention and management.
- Intake #00154852 was related to falls prevention and management.
- Intake #00155518 was related to falls prevention and management.

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

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

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

Non-compliance with: FLTCA, 2021, s. 6 (8)

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff providing direct care to a resident were made aware of and had convenient and immediate access to their plan of care related to a specific fall intervention.

Sources: The resident's clinical record, and interviews with staff.

WRITTEN NOTIFICATION: Documentation

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

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for two separate residents was documented on.

Both residents had falls related interventions in place but none of the interventions had documentation supporting that they had been provided as care planned.

Sources: Both resident's plan of care, Extendicare's Documentation Policy, and interviews with different staff members.

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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 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5).
O. Reg. 246/22, s. 115 (4).

The licensee failed to inform the Director about an incident that resulted in an injury for a resident within the required three business days.

A resident sustained an injury that resulted in a significant change to their health condition. This was reported to the Director five business days later.

Sources: The resident's clinical records, and an interview with Administrator.