

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: October 7, 2025

Inspection Number: 2025-1348-0004

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: Stirling Heights, Cambridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 24-26, 29, October 1-2 and 7, 2025

The inspection occurred offsite on the following date(s): October 3, 2025

The following intake(s) were inspected:

-Intake #00155408 related to prevention of abuse and neglect

-Intake #00155706 related to missing or unaccounted controlled substances

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

Medication Management

Prevention of Abuse and Neglect

INSPECTION RESULTS

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WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 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.

The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.

As per the Ontario Regulations 246/22, section 2 (1) (b) defines physical abuse as "administering or withholding a drug for an inappropriate purpose".

A resident was a recipient of physical abuse when they were not administered their scheduled medications.

Sources: Critical Incident (CI) report, Resident clinical records and Physician's orders, electronic Medication Administration Reports (eMAR), Progress notes, Long-Term Care Home's (LTCH) investigation records, interviews with staff.

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following

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has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when staff had reasonable grounds to suspect that abuse to residents had occurred, that they immediately reported their suspicions and the information upon which it was based to the Director.

Sources: CI report, Zero Tolerance of Abuse and Neglect Program , interviews with the staff.

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 (3) 3.

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

3. A missing or unaccounted for controlled substance.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident related to unaccounted for controlled substances.

Sources: CI report, After Hours Report, LTCH's investigation records, and interview with the Director of Care (DOC).

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WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident was administered their medications, as specified by the physician's order and directions for use.

Sources: Resident's physician's orders and eMAR, LTCH's investigation records, and interview with the DOC.

COMPLIANCE ORDER CO #001 POLICY TO PROMOTE ZERO TOLERANCE

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

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

The licensee shall:

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- 1) Re-educate direct care and management staff on the home's zero tolerance of abuse and neglect program. The education must include a review of the mandatory reporting procedure, investigations process, and any relevant procedures and materials that are part of the home's zero tolerance of abuse and neglect program.
- 2) The education records must be documented and be made available upon an Inspector's request. The record must include all materials reviewed, the date(s) the education was provided and completed, the name(s) of the person(s) who provided the education, and signed by staff.
- 3) Ensure that all components of the root cause analysis checklist is completed for the alleged incidents of abuse as per the home's zero tolerance of abuse and neglect policy. This must include a documentation of all information reviewed for all potential resident(s) involved, including an action plan for preventing a recurrence of the incident.

Grounds

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

As part of the home's zero tolerance of abuse and neglect program, immediate procedures related to incidents of abuse and neglect required the following in no specific order:

- Staff to follow province-specific regulatory reporting requirements
- Ensure a prompt investigation by completing a root cause analysis and gathering information from all involved
- Contact the police

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- Place the alleged staff member on leave of absence (LOA)
- Complete a head-to-toe assessment of the resident(s)
- Inform the Substitute Decision Maker (SDM)/Power of Attorney (POA)

Direct care staff had suspicions that residents were recipients of abuse for an extended period of time and they did not immediately report their suspicions.

When the home became aware of the alleged incidents of abuse, immediate procedures as per the above requirements were not completed and/or delayed.

Immediate responses were not initiated until days later and the home's internal investigation did not encompass all of the required procedures for all of the residents that were potentially involved.

Failing to ensure that all procedures were immediately implemented as per the home's abuse program resulted in delayed actions and identifying the root cause of the incident in a timely manner. This placed residents at risk for being recipients of abuse.

Sources: CI report, Zero Tolerance of Abuse and Neglect Program, LTCH's investigation records, Progress Notes, interviews with the DOC and other staff.

This order must be complied with by November 20, 2025

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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

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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:

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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
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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.