Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: September 25, 2025

Inspection Number: 2025-1051-0006

Inspection Type:
Complaint
Critical Incident

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: Iler Lodge, Essex

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16, 17, 18, 19, 22, 23, 24 & 25, 2025.

The following intake(s) were inspected:

- Intake: 00155374 Critical Incident #2129-000024-25 - Staff to resident alleged abuse.
- Intake: 00155479 Critical Incident #2129-000025-25 - Resident incident resulting in transfer to hospital.
- Intake: 00155468 - Complaint related to care and services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee

prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the second-floor patio was a safe environment for the residents due to lack of lighting. During an observation of the patio, it was found to be dark and the light was not functioning. The next day the light on the patio was functioning.

Sources: A resident's clinical chart, staff interviews, and observations.

Date Remedy Implemented: September 24, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect in a way that fully recognized the resident's inherent dignity and worth.

During an interview with the resident, they told the inspector they'd been treated in a disrespectful and undignified manner by a staff member.

A review of the home's complaint log showed the incident as reported by the resident where the staff member acted and spoke to the resident inappropriately.

Sources: Interview with a resident, staff interviews and review of the home's complaint log.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to immediately report an incident of improper care that resulted in risk of harm to a resident.

The home submitted a Critical Incident (CI) report, outlining an incident where a resident experienced a medical episode with a risk identified in their plan of care, that resulted in transfer to hospital.

Sources: Critical Incident review and a staff interview.

WRITTEN NOTIFICATION: Doors in a Home

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

Non-compliance with: O. Reg. 246/22, s. 12 (2)
Doors in a home
s. 12 (2) The licensee shall ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

In accordance with Ontario Regulation 246/22, section 11 (1) (b), the licensee failed to ensure that the written policy titled, “LTC-Door Safety” was complied with when a resident had an incident.

Sources: A resident’s progress notes, the homes door safety policy, observation of the second-floor patio, and staff interview.

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee failed to ensure that the home’s nutritional care and hydration program included the implementation of interventions to mitigate identified risks related to a resident.

A resident experienced a reaction when they were given a snack from the nourishment cart that contained a specific product. Staff verified that the snacks were not labelled and that the home’s processes were not followed.

Sources: Review of resident’s clinical records, a Critical Incident report, observations and interviews with staff.

COMPLIANCE ORDER CO #001 Communication and Response System

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(e) is available in every area accessible by residents.

The inspector is ordering the licensee to comply with a Compliance Order [#001]:
The licensee must,

1. Complete an audit of all patios in the home, that are accessible to residents, and record if a communication and response system is available. Keep a written record of this document and indicate who completed the audit, the date the audit was completed, and the outcome of the audit.

2. Ensure that a communication and response system is available on all patios that are accessible to residents. Keep a record of the installation details including the date and location of the installation.

Grounds
The licensee failed to ensure that the second-floor patio, which was accessible to residents, was equipped with a resident-staff communication and response system. On September 17, 2025, an observation of the second-floor patio was conducted and there was no communication system available in this area.

The absence of a communication response system on the second-floor patio puts residents at risk of not being able to contact staff to receive assistance when required.

Sources: Observation of the second-floor patio and staff interviews.

This order must be complied with by October 31, 2025

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
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:

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.