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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 12, 2025
Inspection Number: 2025-1356-0001
Inspection Type: 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: Winbourne Park, Ajax

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 5-7, 10-12, 2025

The following intake(s) were inspected:

- An intake related to an outbreak in a resident home area.
- An intake related to Unknown origin injury of resident.
- An intake related to resident injury from a transfer device.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that on every shift, resident's symptoms indicating the presence of infection were monitored when they were on isolation precaution due to an infectious condition. As per the resident's clinical record no documentation indicating the resident's symptoms were monitored on two shifts. The home's IPAC Lead indicated that symptom monitoring was to be completed on each shift by registered staff.

Sources: Review of resident's clinical records; and interview with the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, resident's symptoms indicating the presence of infection were recorded when they were on isolation precaution due to an infectious condition.

The home's IPAC Lead indicated that, the registered staff were expected to document resident's infection status every shift in resident's progress notes until recovered. The IPAC Lead confirmed missing documentation related to resident's infection symptoms on two shifts.

Sources: Review of resident' clinical records; and interview with the IPAC Lead.