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

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| **Report Issue Date:** May 1, 2025 |
| **Inspection Number:** 2025-1356-0002 |
| **Inspection Type:**<br>Complaint |
| **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): April 24- 25, 28 -30, 2025 and May 1, 2025.

The following intake(s) were inspected:

- An intake related to a complaint regarding care

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

## INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan.

The plan of care indicated the use of a sling for transferring the resident. A Personal Support Worker (PSW), stated that a different sling was used to move the resident.

**Sources:** Interviews with PSWs and Falls Lead, and record review plan of care.

## WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that Task: Assisting a Fallen Resident was followed for a resident who sustained an injury.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee was required to ensure that the written policies developed for the falls prevention and management program were complied with.

Specifically, the home's "Task: Assisting a Fallen Resident" indicated that staff should not move the resident until ambulance arrives.

PSW witnessed a resident hitting their head when they fell. The resident was moved from the floor to the bed before the ambulance arrived.

**Sources:** Resident's record review, the home's " Task: Assisting a Fallen Resident" dated January 2015 and interviews with PSWs, Registered Nurse, and Falls Lead.

## WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)**
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has not ensured that the Long-Term Care Home (LTCH) had a written procedure for routine, preventive and remedial maintenance.

Director of Care (DOC) confirmed that the home does not have a written process in place for maintaining equipment, especially when external contractors are involved.

**Sources:** Interviews with Environmental Manager (EM), and DOC, record review of

the receipts.

## WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 108 (2) (d)**
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(d) the final resolution, if any;

The licensee failed to ensure that a documented record was kept in the home that included the final resolution of the complaint related to a resident care.

A complaint related to a resident was received. The complaint record did not include the final resolution of the complainant's reported concerns.

**Sources:** The home's complaint record, and an interview with the DOC.

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