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: July 30, 2025

Inspection Number: 2025-1356-0003

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: Winbourne Park, Ajax

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23-25, 29, 2025
The inspection occurred offsite on the following date(s): July 28, 2025
The following intake(s) were inspected:

- Intake: #00150270 - Improper care of resident.
- Intake: #00152111 - eCorrespondence: Complainant concerns re: residents' rights, and standard of care
- Intake: #00152841 - Improper care of resident by staff resulting in fall, no injury.

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

Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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.

A Critical Incident was submitted regarding concerns of incompetent care. Resident reported that PSW provided bathing without assistance which cause discomfort. Upon review, it was determined that PSW performed the bathing care without the assistance of a second staff member, contrary to the resident's documented Plan of Care, which requires two-person assistance for bathing tasks. During interview with DOC it was acknowledge resident requires to two person to complete bath and PSW failed to follow the plan of care.

Sources : Clinical Records Resident, Interview with Resident and DOC.

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)
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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

In June, 2025, Resident reported concerns to PSW regarding improper care received during personal care. The PSW failed to notify registered staff of the complaint, resulting in a four-day delay in reporting the incident to the Ministry. DOC acknowledge during the interview LTCH failed to the report incident within Ministry timeframe.

Sources: Critical Incident Report, Interview with DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A Personal Support Worker initiated a transfer of a resident without the assistance of

another staff member, despite the resident care plan indicating a two-person assist was required. During the transfer, resident rolled off the bed and fell to the floor. DOC acknowledged during interview this action demonstrated a failure to use safe transferring and positioning techniques, placing the resident at risk of injury.

Sources: Clinical records for Resident, Interview with DOC, And PSW , Investigation notes.

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