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

Ottawa District
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Public Report

Report Issue Date: March 12, 2025

Inspection Number: 2025-1464-0001

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: Arbour Heights, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 3-7, 10-12, 2025

The following intake(s) were inspected:

- Intake: #00133059 - CI #2982-000061-24; Intake: #00138085 - CI #2982-000003-25- Fall of resident with injury.
- Intake: #00136384 - CI #2982-000001-25; Intake: #00138120 - CI #2982-000004-25- Alleged improper/incompetent treatment or care of a resident.
- Intake: #00138686 - CI #2982-000005-25- Enteric outbreak.
- Intake: #00140008 - Complaint related to resident care, responsive behaviours, falls prevention and management, and alleged staff to resident abuse.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's plan of care provided clear directions to staff and others who provided direct care to the resident related to wheelchair (w/c) and use of tilt. A resident's written plan of care showed that there were two interventions related to the w/c and use of tilt. One intervention indicated tilt chair used for comfort (preferably 15-20 degree, not more than 30 degree) and another intervention indicated that the resident uses a w/c and not consented to use tilt option while in the w/c. During an interview with a Personal Support Worker (PSW), they stated that the resident's family member consented to use of the w/c with tilt and that there were no restrictions on the degree of tilt.

Sources: Record review of a resident's progress notes, care plan, and Kardex, and interview with a PSW and a management team member.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 has failed to ensure that the diet texture set out in the plan of care was provided to a resident, as specified in their plan of care. Specifically, on a day in January, 2025, a PSW did not confirm the resident's diet texture before they received food and gave them dessert of the incorrect diet texture, which resulted in the resident choking.

Sources: Record review of a resident's progress notes and care plan, licensee's Investigation file, policy and procedure LTC-Dysphagia Management and Safe Eating, CARE7-010.05, reviewed March 31, 2024, and an interview with a registered staff member and a management team member.

The licensee has failed to ensure that a fall intervention set out in a resident's plan of care was implemented. On a day in March, 2025, Inspector observed the fall prevention intervention that alerts staff if the resident is exiting the room, located between resident's bed and the washroom wall, turned off when the resident was sleeping in their bed.

Sources: Record review of a resident's progress notes, care plan, and Kardex, and interviews with a PSW and a management team member.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (e) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that there is point-of-care signage indicating that enhanced IPAC control measures are in place.

On a day in March, 2025, Inspector observed two residents who were on contact precautions and a resident who was on droplet/contact precautions but did not have point-of-care signage in place.

Sources: Inspector's observations on three units, and an interview with the IPAC Lead.