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: May 14, 2025
Inspection Number: 2025-1464-0003
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: Arbour Heights, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30, 2025 and May 1-2, 5-6, 8-9, 13-14, 2025

The following intake(s) were inspected:

- Intake: #00145124 - CI #2982-000011-25 - Incident with a resident resulting in transfer to hospital
- Intake: #00145283 - CI #2982-000012-25 - Written complaint/response related to the care of a resident
- Intake: #00146618 - CI #2982-000015-25; Intake: #00146795 - CI #2982-000018-25 - Alleged resident to resident sexual abuse
- Intake: #00146652 - CI #2982-000016-25 - Alleged resident to resident physical abuse

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

Medication Management
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure-licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

A resident's Power of Attorney (POA) had submitted a written complaint to the Director of Care (DOC) on a day in April, 2025. The DOC confirmed they did not submit a critical incident report to the Director related to this complaint.

Sources: Review of the DOC's e-mails, critical incidences submitted to the Director, and an interview with the DOC.

WRITTEN NOTIFICATION: Emergency Drug Supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 132 (d)
Emergency drug supply
s. 132. Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(d) that any recommended changes resulting from the evaluation are implemented.

The licensee has failed to ensure that any recommended changes resulting from the evaluation of the maintained emergency drug supply are implemented. In September 2024, a revision was made to the emergency drug supply, which included the addition of Glucagon Nasal Spray (Baqsimi). This revision was not implemented into a resident's Individualized Resident Care Order (IRCO) upon their admission to the home on a day in February, 2025.

Sources: The home's emergency medication list, a resident's Individualized Resident Care Orders, active order summary, prescriber digiorder, electronic medication administration record (EMAR), and interviews with the DOC and a Registered Nurse.