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: November 12, 2025

Inspection Number: 2025-1464-0006

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): November 4-7, and 10, 2025.

The following intake(s) were inspected:

- Intake: #00154384, #00156159 and #00156697 was related to fall of resident, that resulted in an injury.
- Intake: #00159224 was a complaint related to concerns regarding resident care.
- Intake: #00159433 and #00162038 was related to alleged improper/incompetent care of resident by staff.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
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.

On a day in September 2025, a staff member attempted a single person transfer of a resident and the care plan indicated the resident requires two persons, or a lift, for all transfers.

Sources: Review of resident's progress notes, care plan – transfers, and interviews with staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 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.

On a day in November 2025, a resident was found on the floor and the Director of Care (DOC) indicated that their investigation was unable to confirm if safe techniques were used when assisting the resident.

Sources: Review of Critical Incident (CI) report, resident's progress notes, and interviews with DOC and staff.