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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: December 17, 2025

Inspection Number: 2025-1464-0007

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): December 9-12, 15-17, 2025

The following intake(s) were inspected:

- Intake: #00161087 - CI #2982-000037-25 - COVID outbreak
- Intake: #00161440 - CI #2982-000038-25 - Alleged improper/incompetent treatment of a resident
- Intake: #00161945 - Complaint related to resident fall prevention and restraints
- Intake: #00161968 - CI #2982-000040-25 - Alleged physical abuse of a resident by staff
- Intake: #00162115 - Complaint related to resident care
- Intake: #00162133 - CI #2982-000044-25 - Injury of unknown etiology of a resident
- Intake: #00164238 - CI #2982-000049-25 - Fall of a resident resulting in injury

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (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

On a day in October, 2025, a resident sustained a fall with injury. A review of the resident's care plan and Kardex in PointClickCare (PCC), revised on a day in December, 2025, indicated that the resident requires two staff members, and a different specified number of staff as needed for transfers. A review of the resident's Physiotherapist assessment in PCC completed on a day in November, 2025, recommended to use a different specified number of staff for transfers. The resident's transfer logo indicated they required a different specified number of staff

for transfers. In an interview with a Personal Support Worker (PSW), they indicated that the resident is transferred with two staff, sometimes a different specified number of staff. Interviews with an Registered Practical Nurse (RPN), Physiotherapist (PT) and Assistant Director of Care (ADOC) indicated that the resident is to be transferred with a different specified number of staff at all times.

Sources: The resident's care plan, Kardex, progress notes, and Physiotherapist assessment in PCC, the resident's transfer logo in their room, and interviews with a PSW, RPN, PT, and ADOC.

WRITTEN NOTIFICATION: When PASD may be used

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee used a personal assistance services device (PASD) to assist a resident with a routine activity of living. Specifically, when the resident was in their wheelchair (w/c), staff tilted the w/c for a specified reason and use of the PASD was not included in the resident's plan of care.

Sources: Observations of the resident; record review of the resident's written plan of care and progress notes; the licensee's Restraint and PASD Use policy; and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A resident exhibited altered skin integrity and did not receive a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. Specifically, on a day in October, 2025, and a day in November, 2025, the resident exhibited altered skin integrity and a skin assessment had not been completed.

Sources: record review of the resident's assessments, progress notes, care plan and Treatment Administration Record (TAR) record; and an interview with an ADOC.