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: February 4, 2026
Inspection Number: 2026-1464-0001
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): January 30, 2026 and February 2-4, 2026

The following intake(s) were inspected:

- Intake: #00165227 - Complaint related to palliative care
- Intake: #00165328 - CI #2982-000051-25; Intake: #00166754 - CI #2982-000001-26- Alleged improper/incompetent treatment of a resident by staff
- Intake: #00165420 - CI #2982-000053-25 - Influenza A outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care

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 December, 2025, a resident's Power of Attorney (POA) made a verbal complaint related to resident care. A review of the resident's care plan in place at the time of the complaint indicated two different specified directions related to the care concern in two different areas of the care plan.
Interviews with Associate Director of Care (ADOC)'s and a Personal Support Worker (PSW) indicated these directions were confusing.

Sources: Letter to Director of Care (DOC) authored by a resident's POA, a Complaint Investigation Form (CIF), a resident's care plan, and interviews with ADOC's and a PSW.

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 January, 2026, a resident sustained a fall during a transfer. The resident's plan of care at the time of the incident indicated they required a specified direction for transfers. A PSW stated they did not perform this specified direction during the transfer with the resident. During an interview with the DOC, it was confirmed that this was an unsafe transferring technique for the resident.

Sources: A resident's progress notes, care plan and Safe Resident Handling Referral in Point Click Care (PCC), the licensee's investigation notes, and interviews with a PSW and DOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

A review of a Complaint Investigation Form the home used to record complaints and

related investigation(s) found that the Ministry's telephone number and the patient Ombudsman contact information were not provided to the POA as part of the home's response to a verbal complaint. In an interview, an ADOC indicated that the home does not provide this information during follow-up to a verbal complaint if the complainant is satisfied with the home's investigation/response to their concerns.

Sources: Letter to the DOC authored by a resident's POA, a Complaint Investigation Form, and an interview with an ADOC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;

A verbal complaint regarding need for two specified care needs of a resident was not fully documented on the home's Complaint Investigation Form. A review of the document found that one of the POA's concerns was recorded, while the other care concern was not.
During interviews, an ADOC indicated that the resident's POA verbally complained about both care concerns; both issues were investigated.

Sources: Letter to the DOC authored by a resident's POA, a Complaint Investigation Form, and interviews with an ADOC.