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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: July 15, 2025

Inspection Number: 2025-1668-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Axium Extendicare LTC LP, by its general partners, Axium Extendicare LTC GP Inc. and Extendicare LTC Managing GP Inc.

Long Term Care Home and City: Extendicare Countryside, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 7-11, 2025

The following intakes were inspected:

- One intake regarding abuse of a resident;
- One intake regarding concerns about the care of a resident;
- Two intakes regarding improper/incompetent care of a resident;
- One intake regarding neglect of a resident by staff;
- One intake regarding the home's investigation process; and
- One intake regarding hot air temperatures.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and that the plan of care was revised when the resident's care needs changed.

A resident's care plan identified a specific intervention to address a particular care need, however the resident indicated that due to a change in their health condition, the intervention was no longer necessary.

During the inspection, the resident's care plan was revised to remove the specific intervention and to reflect the resident's current care needs.

Sources: Review of a resident's care plan; and an interview with a resident and an Assistant Director of Care (ADOC).

Date Remedy Implemented: July 11, 2025

WRITTEN NOTIFICATION: Plan of care

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 care as outlined in a resident's plan of care was provided as specified, when a staff member assisted the resident without using the required assistive device.

Sources: Critical Incident Submission (CIS) report, the home's investigation notes, and a resident's electronic health record; and interviews with an ADOC and other staff member.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that the Director was immediately notified upon having reasonable grounds to suspect neglect, as the Director was not informed until a number of days after the home became aware of the allegation.

Sources: CIS report, review of the home's policy specific to "Zero Tolerance of Abuse and Neglect Program", and the home's internal investigation notes; and an interview with the ADOC and other staff.

WRITTEN NOTIFICATION: Police notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police force was immediately notified about an allegation of abuse involving a resident and a staff member, which may have constituted a criminal offence.

Sources: CIS report, the home's investigation file, and the home's policy titled, "Incidents That may Constitute a Criminal Offence"; and an interview with Interim Director of Care.

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