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: February 10, 2025
Inspection Number: 2025-1671-0001
Inspection Type: Complaint
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 Limestone Ridge, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22-24, 27-31, 2025 and February 3-6, 10, 2025

The following intake(s) were inspected:

- Intake: #00134809 - Complaint regarding staffing, Infection Prevention and Control (IPAC), and meal service.
- Intake: #00135546 - Complaint with concerns of alleged neglect to a resident.
- Intake: #00137109 - Complaint with concerns of an incident that occurred involving alleged staff to resident abuse.
- Intake: #00137396 - Complaint with concerns regarding dining and meal service, and staffing.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Staffing, Training and Care Standards

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

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff who provide direct care regarding their bathing preference. The resident's care plan indicated their bathing preference was a shower; whereas the Resident Home Areas (RHAs) bath list indicated their bathing preference was a bath. An interview with a Registered Nurse (RN) on January 24, 2025, confirmed this inconsistency, and indicated that the resident's actual preference was a shower.

Sources: Review of resident's care plan, review of the RHAs bath list, and interview with RN
[740787]

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the Power of Attorney (POA) was notified of an incident that occurred on a specified date in January, 2025, regarding a resident.

Sources: Review of resident's progress notes; review of the January, 2025, incident video footage; and interviews with DOC and RPN
[740787]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that staff completed the Point of Care (POC) documentation for a resident's Night Care documentation task on three night shifts in December 2024, and two night shifts between January 1 and 21, 2025.

Sources: Review of resident's POC documentation, and interviews with PSW and ADOC
[740787]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
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.

The licensee has failed to ensure that a report was made to the Director regarding an allegation of physical abuse made by a resident. The resident made a statement to their Power of Attorney (POA) alleging that physical abuse had occurred on a specified date in January, 2025. The resident's POA informed management of the home about the resident's statement alleging physical abuse on the specified date in January, 2025; however, no report was made regarding this allegation to the Director.

Sources: Review of the home's complaint log; review of resident's progress notes; and an interview with Administrator
[740787]

WRITTEN NOTIFICATION: Bathing

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week during the week of January 26th, 2025.

Sources: Bathing schedule for RHA, Documentation Survey Report and progress notes for resident, Interview with RPN and DOC
[741726]

WRITTEN NOTIFICATION: Falls prevention and management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246 / 22, s. 54 (2); O. Reg. 66 / 23, s. 11.

The licensee has failed to ensure that a post-fall assessment was conducted when a resident was lowered to the ground on a specified date in January, 2025. In an interview with Director of Care (DOC) on January 31, 2025, it was confirmed that a post-fall assessment should have been completed.

Sources: Review of the home's video footage regarding the incident involving the resident that occurred in January, 2025; review of the resident's Assessments Tab and progress notes in Point Click Care (PCC); review of the home's Falls Prevention and Management Program Policy RC-15-01-01; review of the home's Risk Management Reports; and interviews with RPN and DOC
[740787]

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident received a weekly skin assessment for a skin tear. The resident was noted to have obtained the skin tear on a specified date in January, 2025, and an initial assessment was completed one day later; however, there were no further assessments of the skin tear completed during the month of January 2025.

Sources: Review of resident's Assessments Tab in Point Click Care (PCC); review of resident's January 2025 medication administration record (MAR) and treatment administration record (TAR), review of resident's current care plan; and interviews with RPN and DOC
[740787]

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 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,

The licensee has failed to ensure that 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 was provided in the response to a verbal complaint made by resident's Power of Attorney (POA) on a specified date in January, 2025.

Sources: Interviews with DOC
[740787]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that on a day in January, 2025, a medication cart located outside the dining room on Rideau Trail home area was secure and locked.

Sources: Observations made by Inspector 740787 and an interview with RPN
[740787]

WRITTEN NOTIFICATION: Administration of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to ensure that the prescriber's directions were followed regarding a resident's treatment. The resident was prescribed a treatment on a specified date in October, 2024, with specific indications on application on bath days. When resident's bath days changed, the original treatment order was discontinued on a day in December, 2024, and was re-entered to reflect the new bath days; however, the direction related to application was not included. In an interview with ADOC it was confirmed that the direction on application had been missed when the order was re-entered and should have been included.

Sources: Review of resident's Prescriber's Digiorder for treatment, review of resident's Prescriber's Orders Review in Point Click Care, and an interview with ADOC
[740787]

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian

who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

1. Provide in-person education with specified Dietary Aid on the Meal Service and Dining Experience Policy #NC-03-01-01. Specifically, education should include a focus on ensuring the correct residents receive the correct diet and texture modifications.

    a) Keep a documented record of who provided the education, the date of the education provided, and the contents of the education.

2. Complete daily meal service audits to ensure adherence to policy #NC-03-01-01, specifically noting if the correct diet and texture modifications is being reviewed prior to serving each resident.

    a) Audits should be completed one meal service a day, for each RHA for a minimum of four weeks.

    b) Keep a documented record of the date the audit was completed, the name of who completed the audit, the RHA and meal service being audited, the names of the staff audited, and corrective actions taken.

Grounds

The licensee has failed to ensure that their written policy related to nutritional care and dietary services was complied with. In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to nutritional care and dietary services is complied with.

Specifically, a Dietary Aid (DA) did not comply with the Meal Service and Dining Experience policy, when they did not refer to the diet list as they served lunch on a

specified Resident Home Area (RHA). On a day in January, 2025, inspector observed the DA plating and providing PSW staff with a regular texture meal, for a resident who required a texture modified diet. The DA confirmed they had not referred to the diet list, when PSW staff advised of error. Following this, The DA was observed not referring to the diet list for two subsequent residents.

Sources: Observation of Dining Service on RHA January, 2025; Meal Service and Dining Experience Policy #NC-03-01-01; Interviews with PSW, Dietary Aid, and Dietary manager
[741726].

This order must be complied with by March 24, 2025

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Provide in-person education to all direct care and registered staff, regarding the selection, donning, doffing and disposal of PPE. The education must include a return demonstration by staff of proper selection and sequence.

a) Keep a documented record of who provided the education, the date of the education provided, the name of the staff in attendance, and the contents of the education.

2. Conduct daily PPE audits for all direct care and registered staff, for a minimum of four weeks.

    a) Audits should include appropriate selection, donning and doffing and disposal of PPE, as well as corrective actions taken when the correct process is not followed.

    b) Keep a documented record of the date the audit was completed, the name of who completed the audit, the names of those staff audited, and corrective actions taken.

3. Review all job roles within the home, to clearly identify the IPAC skills that are required for each role.

4. Develop and implement a process to ensure all job roles within the home are audited. The audits must ensure that all staff can perform the IPAC skills required of their role, and be completed at a minimum on a quarterly basis.

5. Review and revise (as necessary), the policy and procedure in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach. The procedure must clearly identify high touch contact area frequencies in outbreak, and non-outbreak settings.

6. Develop a staffing plan that outlines who is responsible for the cleaning of high touch contact areas, and demonstrates adequate personnel are available on each shift to complete the required cleaning. The plan should include outbreak, and non-outbreak settings.

7. Develop and implement a tracking sheet for the cleaning of high contact areas, to ensure they are being cleaned at the required frequency. Tracking sheets should include the RHA being cleaned, the surface being cleaned, the

date and time the cleaning is being completed, and who is completing the cleaning.

8. Provide education to all staff, in the department that will be completing the cleaning, on the items listed in number 5 and 7.

    a) Keep a documented record of who provided the education, the date of the education provided, the name of the staff in attendance, and the contents of the education.

9. Conduct daily audits to ensure the tracking sheets in number 7. are completed, as required, for a minimum of four weeks.

    a) Keep a documented record of the date the audit was completed, the name of who completed the audit, and corrective actions taken when gaps are identified.

Grounds

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

1) In accordance with additional requirement 9.1 (f) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal were followed in the IPAC program.

Specifically, Personal Support Worker (PSW) staff in two separate RHAs did not select or apply the PPE required for resident rooms requiring additional precautions.

On a specified date in January, 2025, during an IPAC focused tour of the home, a PSW was observed not donning eye protection prior to entering a residents room on a specific RHA, requiring additional contact and droplet precautions. Upon exit, The PSW was observed not removing their face mask until after they had exited the room. An RPN stated in an interview, eye protection was optional, however during

an interview with IPAC Manager, it was confirmed that eye protection in a room requiring additional contact and droplet precautions is required and should have been worn.

On a second observation during the tour, two PSWs were observed to not be wearing a disposable gown, while providing direct care to a resident who required additional contact precautions on a separate RHA.

Sources: Inspectors observation on a date in January, 2025; Interviews with PSWs, RPN, and IPAC Manager
[741726]

2) In accordance with additional requirement 7.3 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that audits are performed regularly (at least quarterly) to ensure that all staff can perform the IPAC skills required of their role.

During interviews with IPAC Manager on a specified date in January and February, 2025, it was confirmed that the LTCH did not have an auditing tool in circulation, as such the quarterly audits to ensure all staff can perform the IPAC skills required of their role had not been completed.

Sources: Interview with IPAC Manager.
[741726]

3) In accordance with additional requirement 5.6 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure the following:

1. That there are policies and procedures in place to determine the frequency of surface cleaning and disinfection using a risk stratification approach.
2. That surfaces are cleaned at the required frequency.
3. That adequate personnel are available on each shift to complete required surface cleaning and disinfection.

Specifically, the Long-Term Care Home (LTCH) does not have a policy or procedure in place that specifies the frequency of cleaning and disinfection. A document titled High Touch Surface Cleaning Checklist is currently in use, however on several dates in January, 2025, on several RHAs, this document was not completed as required.

During an interview with Support Services Manager on a specified date in January, 2025, it was confirmed that RSAs are responsible for the cleaning of high touch surface areas.

The current scheduling of RSAs is one per floor, however on seven days in January, 2025 it was noted on the nursing assignment sheets for there to be only two RSAs scheduled for the home, and on four days in January, 2025 only one RSA. On these dates, there was no High Touch Surface Checklist completed. The LTCH was noted to be on an enteric outbreak from January 16th - 29th, 2025.

Sources: Inspectors observation on a specified date in January, 2025; High Touch Area Tracking Sheet for all three floors; General Surfaces Cleaning Policy #HL-05-01-14; Cleaning Frequency #HL-05-01-09; Staffing assignments for January 10-26, 2025; Interviews with RSA, IPAC Manager, Support Services Manager, DOC, and Resident Program Manager
[741726]

This order must be complied with by March 31, 2025

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

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.