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: July 8, 2025

Inspection Number: 2025-1831-0002

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 Crossing Bridge, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23, 24, 25, 26, 27 and 30, 2025, and July 2, 3, 4 and 7, 2025.

The following intake(s) were inspected:

- Intake: #00145428 / Critical Incident System (CIS) report 3071-000002-25 was related to a disease outbreak.
- Intake: #00146155 / CIS report 3071-000003-25 was related to a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.
- Intake: #00146602 / CIS report 3071-000004-25 was related to the licensee's complaints procedure.
- Intake: #00147139 was a complaint related to concerns about the care of a resident.
- Intake: #00147459 was a complaint related to concerns about the care of a resident.

- Intake: #00147663 / CIS report 3071-000006-25 was related to a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.
- Intake: #00148398 / CIS report 3071-000008-25 was related to an incident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.
- Intake: #00148484 was a complaint related to concerns about the care of a resident.
- Intake: #00149091 / CIS report 3071-000009-25 was related to the licensee's complaints procedure.
- Intake: #00149224 was a complaint related to concerns about the care of a resident.
- Intake: #00149584 was a complaint related to concerns about the care of a resident.
- Intake: #00149725 / CIS report 3071-000010-25 was related to the licensee's complaints procedure.
- Intake: #00150177 was a complaint related to concerns about the care of residents.
- Intake: #00150830 / CIS report 3071-000013-25 was related to the licensee's complaints procedure.
- Intake: #00151469 / CIS report 3071-000014-25 was related to an allegation of improper care provided by a staff member to a resident that resulted in a risk of harm to the resident.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Safe and Secure Home

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

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: O. Reg. 246/22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that there were written strategies to prevent and respond to exit seeking behaviours exhibited by a resident.

Sources: Observation, review of the resident's health care record and interviews with staff.

Date Remedy Implemented: July 7, 2025.

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.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident. Specifically, a Personal Support Worker transferred the resident without using the required number of staff, as identified in the resident's plan of care, to transfer them.

Sources: Observation, review of the resident's health record and interviews with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and

the risk of injury.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee was required to ensure that written policies developed for the falls prevention and management program were complied with.

The licensee has failed to comply with the home's falls prevention and management program when the post-fall policy was not complied with, related to the completion of Head Injury Routine, after the resident had falls.

Sources: Review of the resident's health record and the Head Injury Routine Policy and an interview with an Assistant Director of Care.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that treatment interventions for wound healing were provided to a resident. Specifically, a device was not charged to ensure it ran as ordered. Staff did not document that they checked the device to ensure it was functioning and that the wound covering remained intact, as required.

Sources: Review of the resident's health records and interviews with staff.