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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 8, 2025
Original Report Issue Date: April 1, 2025
Inspection Number: 2025-1330-0002 (A1)
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: Longfields Manor, Nepean

AMENDED INSPECTION SUMMARY

This report has been amended to:
NC #002 was amended to remove one of the non-compliances issued under "FLTCA s. 6(7) - Duty of licensee to comply with plan".

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 19, 20, 21, 24, 25, 26, 27, 28, 31, 2025 and April 1, 2025

The following intake(s) were inspected:

- Intake: #00137113 - related to alleged resident-to-resident abuse.
- Intake: #00138762 - related to a resident's fall resulting in a significant change in the resident's condition.

- Intake: #00138815 and Intake: #00140087 - complaint with concerns about a resident's care and breach of privacy.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a nursing staff member afforded a resident privacy in treatment and in caring for their personal needs by using a personal device to record the resident.

Sources: Critical incident report, written warning letter and interview with Administrator and ADOC.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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 set out in a resident's plan of care, for the resident to be monitored using Behavior Support Ontario - Dementia Observation System (BSO-DOS), was provided to the resident as specified in their plan. Specifically, the BSO-DOS mapping to document the monitoring of the resident was not completed for specific dates and time periods.

Sources: resident's BSO - DOS mapping data collection sheets, PSW, and ADOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions

are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviors, the Behavior Support Ontario - Dementia Observation System (BSO - DOS) mapping tool that was initiated was analyzed in the reassessments of the resident. Two Personal Support Workers reviewed the BSO-DOS Worksheets and stated that the analysis should have been completed.

Sources: resident's BSO - DOS mapping worksheets, Interviews with PSW and ADOC.