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

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Public Report

Report Issue Date: April 3, 2025
Inspection Number: 2025-1347-0002
Inspection Type: 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: Northridge, Oakville

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24-28, 31 and April 1-3, 2025

The following intakes were inspected:
Intake: #00132932 – Critical Incident (CI) – Housekeeping, Laundry, and Maintenance Services
Intake: #00135062 – CI – Falls Prevention and Management
Intake: #00136076 – CI – Continence Care
Intake: #00134020 – CI – Prevention of Abuse and Neglect
Intake: #00136116 – CI – Prevention of Abuse and Neglect
Intake: #00135470 – CI – Prevention of Abuse and Neglect
Intake: #00135574 – CI – Prevention of Abuse and Neglect

The following intakes were completed:
Intake: #00135028 – CI – Falls Prevention and Management

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

Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
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:
4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident's right to freedom from abuse was fully respected and promoted when an item was thrown at the resident by a staff member.

Sources: LTCH's investigation records, resident's clinical records, Critical Incident (CI), interview with staff.

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the bed systems in the home were maintained in good repair.

On a date in 2024, a resident fell from their bed due to the bed being broken. Resident did not sustain any injuries.

A member in management reported that there was a concern with the bed system and that this was identified during the home's annual audits, but there was no documentation of any follow-up actions taken.

Sources: Resident's clinical records, video surveillance of the incident, CI, and interviews with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by a staff member.

Sources: video surveillance of interaction between staff member and resident, interview with staff, Critical Incident (CI), LTCH's investigation notes.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure staff complied with the home's prevention of abuse and neglect policy when they alleged neglect of multiple residents and did not take the required action of reporting immediately to the charge nurse and Director, completing skin assessments, notifying substitute decision makers (SDM) and police.

Sources: LTC - Interventions for victims of abuse and neglect (reviewed March 31, 2024), Resident non-abuse (reviewed Nov 12, 2024), email from staff, Home's investigation notes, progress notes for residents, skin assessment records for residents, interview with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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 person who had reasonable ground to suspect abuse of a resident by anyone immediately reported the suspicion and the information upon which it was based to the Director.

Pursuant to FLTCA, 2021, s. 154 (3) the licensee was vicariously liable for staff members failing to comply with s. 28 (1).

On a date in 2024, a staff member witnessed the abuse of a resident by another staff member, which the home determined was an incident of abuse or neglect of a resident. A member of management acknowledged that the staff member who witnessed the act did not report the incident immediately as required which resulted in a delay in reporting the incident to the Director.

Sources: video surveillance of interaction between staff members and the resident, interview with staff, CI, LTCH's investigation notes.

WRITTEN NOTIFICATION: Pain Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee failed to ensure that strategies to manage pain were provided when a

resident experienced pain as a result of a wound.

Sources: Resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that the techniques and interventions, to prevent, minimize or respond to the responsive behaviours of a resident were implemented on an interdisciplinary basis when a staff member did not implement the home's response to responsive behaviors when the resident was responsive.

Sources: LTCH's investigation records, resident's clinical records, CI, interview with staff, the home's Dementia Care Tool titled "STOP Aggressive Responsive Behaviors."

WRITTEN NOTIFICATION: Responsive behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;

(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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 failed to ensure that a resident's plan of care included behavioural triggers, strategies, and actions to manage their behaviours.

On a date in 2024, a resident demonstrated aggression towards a staff member. Resident had a history of responsive behaviours towards staff prior to this incident, however, their responsive behaviours were not documented in their plan of care until after the incident.

Sources: Resident's clinical records and interview with staff.