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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: November 21, 2025
Inspection Number: 2025-1356-0005
Inspection Type: Critical Incident Follow up
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: Winbourne Park, Ajax

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13-14, 17-18 and 21, 2025. The inspection occurred offsite on the following date(s): November 19, 2025.
The following intake(s) were inspected:

- An intake related to a follow-up compliance order.
- An intake related to an outbreak.
- An intake related to the fall of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1356-0004 related to FLTCA, 2021, s. 13 (1)

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

Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 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.

During interviews with staff, they confirmed that the resident was not safely transferred according to the home's policy.

Sources: Policies, a resident's clinical health records and interviews with a resident and staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

A review of a resident's clinical health records revealed the resident had a number of falls.

During an interview with staff, they confirmed that the resident required frequent reminders and increased monitoring. Staff acknowledged that the resident's care plan should have been updated with this information.

Sources: Policies, a resident's clinical health records, observations and interviews with a resident and staff.

WRITTEN NOTIFICATION: Pain management

NC #003 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.

A resident sustained a fall, with documentation that indicated the resident had expressed pain. Staff confirmed interventions were not implemented for the resident.

Sources: Policies, a resident's clinical health records and interviews with a resident and staff.

WRITTEN NOTIFICATION: Responsive behaviours

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

A review of a resident's clinical health records indicated that an assessment was initiated. Further review of documentation revealed that the resident had expressions of responsive behaviours. During an interview with staff, they acknowledged the resident's care plan should have included interventions and strategies related to the resident's expressions of responsive behaviours.

Sources: Policies, a resident's clinical health records and interviews with staff.

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