

**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:** July 31, 2025

**Inspection Number:** 2025-1671-0005

**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 Limestone Ridge, Kingston

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23 - 25, 28 - 31, 2025

The following intake(s) were inspected:

- Intake: #00149654 - CI #3070-000042-25 - Alleged resident to resident abuse
- Intake: #00149904 - CI #3070-000043-25 - Alleged resident to resident abuse
- Intake: #00150811 - CI #3070-000044-25 - Alleged staff to resident neglect
- Intake: #00151843 - Complaint related to temperature in the home, food quality, missing items, and resident care

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

Resident Care and Support Services  
Skin and Wound Prevention and Management

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Food, Nutrition and Hydration  
Housekeeping, Laundry and Maintenance Services  
Prevention of Abuse and Neglect  
Responsive Behaviours

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Documentation

NC #001 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 specified monitoring was documented for a resident, for the month of June 2025.

**Sources:** Review of specified documentation for a resident, and an interview with a staff member

### WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 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

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promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure their policy to promote zero tolerance was complied with.

The home's policy entitled Zero Tolerance of Abuse and Neglect Program, and related procedure entitled Immediate Response and Mandatory Reporting of Abuse or Neglect, indicated that interventions to deal with persons who have allegedly abused or neglected must be completed immediately, which included staff members being placed on a Leave of Absence pending the results of the home's investigation.

In regards to an allegation of neglect for a resident, that occurred on a specified day in June 2025, two staff members, who were potentially responsible for the alleged neglect, were not placed on immediate administrative leave. The alleged staff members both worked shifts on a specified day in June, 2025 after the allegation had been made. They were placed on administrative leave on a later date in June 2025.

**Sources:** Review of the home's policy Zero Tolerance of Abuse and Neglect Program; review of the home's procedure Immediate Response and Mandatory Reporting of Abuse or Neglect; review of the home's staff schedules for specified days in June 2025; and interviews with staff members

**WRITTEN NOTIFICATION: Reporting certain matters to Director**

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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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 an immediate report was made to the Director regarding an alleged incident of neglect concerning a resident. The alleged incident of neglect occurred on a specified day in June 2025; however, was not reported to the Director until a later specified day in June 2025.

**Sources:** Review of the Critical Incident Report (CIR), and interviews with staff members

## **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) (i)**

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,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure a resident received a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate

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assessment instrument that is specifically designed for skin and wound assessment.

Specifically, a resident who sustained an injury as a result of an interaction with another resident, that occurred on a specified day in June 2025, did not receive a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

**Sources:** Review of a resident's clinical records, review of the licensee's Risk Management, policy and procedures entitled Extendicare Skin and Wound Program: Wound Care Management and Extendicare Skin and Wound Program: Prevention of Skin Breakdown, and interviews with staff members

## **WRITTEN NOTIFICATION: Responsive behaviours**

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.**

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:

3. Resident monitoring and internal reporting protocols.

The licensee has failed to comply with their written policy and internal protocols related to responsive behaviours for a resident.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to responsive behaviours is complied with.

Specifically, staff who were responsible for documenting an incident in risk

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management and/or a Responsive Behaviour Debrief assessment for a resident failed to complete the assessment related to an alleged resident to resident incident of abuse, that occurred on a specified day in June 2025.

**Sources:** Review of a resident's progress notes and assessments, the licensee's Risk Management, Extendicare's Responsive Behaviours Policy, Extendicare's Responsive Behaviour Documentation, the Critical Incident System (CIS) report, and an interview with a staff member

**WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act**

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 112 (3)**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to ensure that a final report was provided to the Director within a period of time specified by the Director.

On a specified day in June 2025, a Critical Incident Report (CIR) was submitted to the Director for an allegation of neglect regarding a resident. The licensee did not provide the final report until a specified day in July 2025.

**Sources:** Review of a CIR and an interview with a staff member