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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: November 25, 2025
Inspection Number: 2025-1668-0008
Inspection Type: 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 Countryside, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 17-21, 2025

The following intake(s) were inspected:
- One Intake related to a fall of resident resulting in an injury.
- Two Intakes related to an allegation of Improper/incompetent care of resident.
- One Intake related to an outbreak.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and 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.

On a specified date, a resident was transferred improperly by a staff member and sustained a fall.

Sources: CI report; resident's clinical records; review of the home's internal investigation; review of the home's policy, titled "Safe Resident Handling; interviews with the Assistant Directors of Care (ADOC) and other staff.

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On a specified date, a resident was served an improper dietary item that did not meet their special needs.

Sources: CI report; resident's clinical records; the home's internal investigation; review of the home's policy titled, "Meal Service and Dining Experience"; interview with the ADOC and other staff.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

On a specified date, a resident sustained a fall with injury and a report was not submitted to the Director until 7 days later.

Sources: CI report; a resident's clinical records; and an interview with the ADOCs.

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