

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Public Report

Report Issue Date: July 9, 2025

Inspection Number: 2025-1332-0003

Inspection Type:

Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Brampton, Brampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 23-27, 2025, and July 7-9, 2025.

The following intake(s) were inspected:

- Intake: #00139147, related to pain management.
- Intake: #00145920, related to falls prevention and management.
- Intake: #00149157, related to falls prevention and management, and resident care and support services.
- Intake: #00146520, a complaint related to prevention of abuse and neglect.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (2)

General requirements

s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident's continence care intervention was documented on multiple dates.

Sources: The resident's clinical records, and interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Foot care and nail care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 39 (1)

Foot care and nail care

s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Sources: The Critical Incident System (CIS) Report, the home's Nail and Foot Care

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policy, The resident's clinical health records; Interviews with staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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).

The licensee has failed to comply with the home's falls prevention and management program when an intervention was not implemented as outlined in a resident's plan of care.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program are complied with.

Specifically, the home's falls prevention and management program policy indicated that the care staff will implement any strategies and interventions as outlined on the resident's plan of care, which did not occur for the resident when they were not wearing their hip protectors at the time of the fall. The resident sustained an injury.

Sources: The CIS Report, The home's Falls Prevention and Management Program policy, the resident's clinical health records; Interviews with staff.