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: September 3, 2025
Inspection Number: 2025-1336-0004
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Cobourg, Cobourg

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 2, 3, 2025

The following intake(s) were inspected:
An Intake related to the fall of a resident resulting in injury.

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

Skin and Wound Prevention and Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b)
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,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident received a weekly skin assessment by Registered Staff, using a clinically appropriate assessment instrument specifically designed for skin and wound assessment, and received immediate treatment and interventions to promote healing, and prevent infection.

A Critical Incident Report (CIR) was received by the Director related to the fall of a resident resulting in injury.

Registered staff did not document the weekly skin assessment for a resident on a specific date and did not document treatment orders for the resident on three specific dates, as required.

Sources: A CIR, the home’s policies and procedures, a resident’s electronic health records, and an interview with staff.

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