

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: July 31, 2025

Inspection Number: 2025-1323-0003

Inspection Type:

Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23, 24, 28 to 31, 2025.

The following intake(s) were inspected:

- Intake: #00151725 - resident to resident physical abuse with injury.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to a resident, as specified in the plan, when registered staff failed to re-attempt to administer a specific medication on multiple dates when the resident refused or was sleeping, contributing to an escalation of behaviours in the month leading up to the critical incident altercation with a co-resident. A Registered Practical Nurse (RPN) and the Behavioural Supports Ontario (BSO) Lead both confirmed that when a cognitively impaired resident refuses medication or is sleeping when the dose is due, a re-attempt should be made. The care plan directed staff to re-attempt when refusing or resisting care.

Sources: critical incident report, resident clinical records, staff interviews (RPN and BSO Lead).

WRITTEN NOTIFICATION: Behaviours and Altercations

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

Non-compliance with: O. Reg. 246/22, s. 60 (a)

Behaviours and altercations

s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's

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behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee failed to ensure that, procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The home's expectation to provide a prompt assessment after receiving a Behavioural Supports Ontario (BSO) referral was not met, when no assessment was made for nine days despite the awareness that the resident's behaviour posed a risk to injuring others. The BSO Lead discovered during their assessment that Personal Support Workers (PSWs) were failing to report the behaviour as it was occurring, and registered staff were clearing electronic alerts for the behaviour without taking action.

The Director of Care (DOC) confirmed that verbal direction had been given to keep two residents apart, and the Resident Care Aide (RCA) should have redirected the resident when they passed next to the other resident in the dining room. Two RCA's were unaware of the direction to keep the residents apart, and the written instructions contained no direction for this.

Sources: resident dining room observation, resident clinical records, Alert Listing reports, staff interviews (two RCA's, BSO Lead and DOC).

**WRITTEN NOTIFICATION: Infection Prevention and Control
Program**

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

Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

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Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in a resident were monitored in accordance with any standard or protocol issued by the Director under subsection (2), when staff failed to document on every shift that they were monitoring a resident's infection, after the physician prescribed a pharmaceutical treatment for the infection, on a specified date. The IPAC Manager confirmed that the documentation in the progress notes was more related to medication administration than symptom monitoring.

Sources: resident clinical records, IPAC Manager interview.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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