

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: June 27, 2025

Inspection Number: 2025-1328-0003

Inspection Type:

Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Lakefield, Lakefield

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 16-20, 23-26, 2025

The following intake(s) were inspected:

Intake #00141113 - Follow-up #1 Compliance Order (CO) #004 / 2025_1328_0001, FLTCA, 2021, s. 6 (1) (a), Plan of Care, Compliance Due Date (CDD) May 2, 2025

Intake #00141114 - Follow-up #1 - CO #007 / 2025_1328_0001, O. Reg. 246/22, s. 93 (2) (a) (ii), Housekeeping, CDD May 2, 2025

Intake #00141115 - Follow-up #1 - CO #008 / 2025_1328_0001, O. Reg. 246/22, s. 102 (2) (b), IPAC Program, CDD April 18, 2025

Intake #00141116 - Follow-up #1 - CO #002 / 2025_1328_0001, FLTCA, 2021, s. 33 (1) (b), Policy to minimize restraining of residents, etc. CDD May 2, 2025

Intake #00141117 - Follow-up #1 - CO #003 / 2025_1328_0001, FLTCA, 2021, s. 3 (1) 4. Residents' bill of rights, CDD May 2, 2025

Intake #00141118 - Follow-up #1 - CO #001 / 2025_1328_0001, FLTCA, 2021, s. 24 (1), Duty to protect, CDD May 2, 2025

Intake #00141119 - Follow-up #1 - CO #005 / 2025_1328_0001, O. Reg. 246/22,

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s. 58 (4) (b), Responsive Behaviours, CDD May 30, 2025
Intake #00141120 - Follow-up #1 - CO #006 / 2025_1328_0001, O. Reg. 246/22,
s. 58 (4) (c), Responsive behaviours, CDD May 30, 2025
Intake #00144996 - Critical Incident System (CIS) related to resident to resident
alleged abuse
Intake #00145369 - Complaint concerns regarding resident care and services
Intake #00147010 - CIS related to resident to resident alleged abuse
Intake #00147214 - CIS related to resident to resident alleged abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #004 from Inspection #2025-1328-0001 related to FLTCA, 2021, s. 6 (1) (a)

Order #007 from Inspection #2025-1328-0001 related to O. Reg. 246/22, s. 93 (2) (a) (ii)

Order #008 from Inspection #2025-1328-0001 related to O. Reg. 246/22, s. 102 (2) (b)

Order #002 from Inspection #2025-1328-0001 related to FLTCA, 2021, s. 33 (1) (b)

Order #003 from Inspection #2025-1328-0001 related to FLTCA, 2021, s. 3 (1) 4.

Order #001 from Inspection #2025-1328-0001 related to FLTCA, 2021, s. 24 (1)

Order #005 from Inspection #2025-1328-0001 related to O. Reg. 246/22, s. 58 (4) (b)

Order #006 from Inspection #2025-1328-0001 related to O. Reg. 246/22, s. 58 (4) (c)

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

Resident Care and Support Services

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Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)

Responsive behaviours

s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,

(c) co-ordinated and implemented on an interdisciplinary basis.

The licensee has failed to ensure that written approaches to care for responsive behaviours was coordinated and implemented on an interdisciplinary basis. A resident exhibited responsive behaviours. They consistently exhibited specific behaviours and staff failed to consult the home's internal behavioural supports in the home. Failure to co-ordinate responsive behavioural care may have impacted the resident's adherence to care and services.

Sources: clinical record, BSO (Behavioural Supports Ontario) rounding summary, the licensee's policy entitled Mental Health Assessment and Support, interviews with staff and complainant.



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

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