

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:** August 21, 2025

**Inspection Number:** 2025-1328-0004

**Inspection Type:**  
Critical Incident

**Licensee:** Extencicare (Canada) Inc.

**Long Term Care Home and City:** Extencicare Lakefield, Lakefield

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 15, 19, 20, 21, 2025.

The following intake(s) were inspected:

- An intake regarding an unexpected death of a resident.
- An intake regarding an incident that resulted in a resident being transferred to the hospital.
- An intake regarding a resident to resident physical altercation.
- An intake regarding a resident fall that resulted in a change in condition.

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

- Resident Care and Support Services
- Responsive Behaviours
- Prevention of Abuse and Neglect
- Falls Prevention and Management

## INSPECTION RESULTS

### 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 a resident's plan of care for bed mobility was followed. The plan of care directed to turn and reposition the resident every two hours. The internal investigation records confirmed that staff did not reposition the resident or conduct safety checks prior to the incident.

**Sources:** A resident's care plan, point-of-care documentation, and internal investigation records.



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

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