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: January 15, 2026
Inspection Number: 2026-1328-0001
Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Lakefield, Lakefield

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-9, 12-14, 2026
The inspection occurred offsite on the following date(s): January 15, 2026

The following intake(s) were inspected:
An intake related to a complainant regarding a bed refusal.
An intake related a complaint regarding allegations of neglect.
An intake related to a medication incident.
An intake related to a resident to resident altercation.
An intake related to a resident altercation towards a co-resident.
An intake related to a complaint related to delayed treatment for a resident.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Responsive Behaviours
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to freedom from abuse.

A resident sustained a injury after a co-resident had responsive behaviours towards them.

Sources: Critical Incident Report (CIR), resident's investigation notes, interview with a resident.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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.

A complaint was received by the Director regarding a resident's clinical test. The family alleged that treatment was not initiated and the medical doctor was not notified of the results as specified in the resident's plan of care. At the time of admission, written documentation was provided outlining the treatment plan for the resident in the event of abnormal test results.

Sources: A resident's clinical records.

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home

s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

A resident's application was declined for acceptance for admission to the home. A letter to the applicant cited the home lacked nursing expertise. The management staff confirmed the home had a support program that could provide interventions if the applicant had responsive behaviours, as well as collaboration with the Physician and family to support the applicant.

Sources: The home's policy, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

A resident sustained altered skin integrity after a altercation with a co-resident. The staff confirmed a weekly skin reassessment was not completed.

Sources: The home's policy, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

A resident had responsive behaviours towards a co-resident. The staff confirmed that the resident's care plan should have been updated after this incident to include interventions to minimize the risk of responsive behaviours towards a co-residents but it was not.

Sources: A resident's clinical records, interview with staff

WRITTEN NOTIFICATION: Police notification

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

1. An allegation of resident-to-resident physical abuse involving a resident was not immediately reported to the police as required.

Sources: CIR, a resident's clinical records, Long Term Care Homes Elder Abuse Reportable Incident Form Police Service.

2. A Personal Support Worker (PSW) indicated that a resident had responsive behaviours towards a co-resident. A resident to resident physical altercation occurred and one of the resident's sustained an injury. The staff confirmed the police were not notified immediately regarding the above incident.

Sources: CIR, email correspondence, Long Term Care Homes Elder Abuse Reportable Incident Form Police Service, investigation notes, interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

A medication incident report and CIR indicated that a Registered Practical Nurse (RPN) administered medication to a resident that was not prescribed for the resident, as a result the resident was transferred to hospital.

Sources: CIR, the resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A complaint was received by the Director regarding medication administration. A medication was ordered for a resident; however, the medication was not administered to the resident until four months later.

Sources: A resident's clinical records, interview with staff.

COMPLIANCE ORDER CO #001 Responsive behaviours

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive

behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Provide re-education to all Personal Support Workers (PSWs) on a Home Area regarding the use of the Dementia Observation System (DOS) tool, including its purpose and the correct process for completion.

Grounds

1. A resident and a co-resident displayed responsive behaviours towards one another. The staff confirmed the registered staff were to initiate a DOS for the resident when they had responsive behaviours towards the co-resident. Record review of the DOS for the resident indicated it was not initiated until several hours after the incident occurred. There was an increased risk when the DOS was not implemented after the incident as staff may have missed triggers and patterns related to the resident's responsive behaviours to help develop a plan of care.

Sources: A resident's clinical records for a resident, interviews with staff.

2. A Critical Incident was submitted to the Director when a resident had responsive behaviours towards a co-resident. The co-resident sustained an injury when the resident had responsive behaviours towards them. Two copies of the DOS were reviewed, neither of which captured the events that occurred on the date of the occurrence.

Additionally, the medical doctor ordered a medication to be discontinued and another medication to be started. A DOS assessment was supposed to begin for five days; however, this was not completed as required.

The Behavioural Support Ontario RPN confirmed that although direct care staff had been trained on the use of the DOS tool the assessments were not completed accurately. Although some interventions were implemented, there was a gap in the resident's plan of care when the resident did not have supervision over a period of time.

This gap resulted in the alleged responsive behaviours towards a co-resident. When staff did not complete the DOS for the resident, there was an increased risk that appropriate assessments, reassessments and interventions may be missed to manage the resident responsive behaviours.

Sources: A resident's clinical Records, interview with staff and the resident.

3. A resident displayed responsive behaviours towards a co-resident. The staff confirmed the registered staff were to initiate a DOS after the resident had responsive behaviours towards the co-resident. Record review of the DOS for the resident indicated it was not initiated until several hours after the incident occurred. There was an increased risk when the DOS was not implemented after the incident as staff may have missed triggers and patterns related to the resident's responsive behaviours to help develop a plan of care.

Sources: A Resident's clinical records, interviews with staff.

This order must be complied with by March 16, 2026

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO, issued in inspection, 2025-1328-0001, issued on 2025-02-27

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.