

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: June 6, 2025

Inspection Number: 2025-1171-0004

Inspection Type:

Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Laurier Manor, Gloucester

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 2, 3, 4, 5, and 6, 2025.

The following intake(s) were inspected:

- Intake: #00146432 - Complaint with concerns regarding fall prevention, and reporting of falls of a resident.
- Intake: #00147254 - Alleged incident of staff to resident physical abuse.
- Intake: #00147272 - Complaint with concerns related to a resident for alleged abuse, falls, skin and wound, and plan of care.
- Intake: #00149061- Alleged incident of staff to resident physical abuse.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Prevention of Abuse and Neglect
Falls Prevention and Management

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

INSPECTION RESULTS

WRITTEN NOTIFICATION: Failure to notify substitute decision maker.

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that the resident's substitute decision maker (SDM) was given an opportunity to participate in the development and implementation of the resident's plan of care. Specifically, on a day in the month of April 2025, when a resident, sustained a fall, their substitute decision maker was not notified.

Sources: resident's health care records, licensee internal investigation notes, interviews with staff.