

**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:** April 20, 2026

**Inspection Number:** 2026-1093-0004

**Inspection Type:**

Complaint  
Critical Incident

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

**Long Term Care Home and City:** Extendicare Medex, Ottawa

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 15, 16, 17, 20, 2026

The following intake was completed in this complaint inspection:

- Intake #00168491 related to an allegation of physical abuse causing an injury, whistleblowing retaliation and resident care.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake #00169549/CI #2579-000003-26 was related to a fall that resulted in a significant change in condition.

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

Whistle-blowing Protection and Retaliation  
Prevention of Abuse and Neglect  
Responsive Behaviours  
Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting certain matters to Director

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

**Non-compliance with: FLTCA, 2021, s. 28 (1) 1.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On a specified date a resident was observed with an injury, with no known cause at that time. According to a Associate Director of Care (ADOC) the investigation found that three Personal Support Workers (PSW) proceeded with care while the resident was exhibiting responsive behaviours. A specific approach to care as outlined in the resident's plan was not implemented, resulting in the injury. The ADOC indicated the incident of improper care was not reported to the Director.

Sources: Interviews with a ADOC, a Director of Care (DOC) , Resident's care plan, investigation notes.

### WRITTEN NOTIFICATION: Responsive Behaviours

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

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**

Responsive behaviours

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s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

On a specified date a resident was observed with an injury, with no known cause at that time. According to a ADOC the investigation found that three specific Personal Support Workers (PSW) proceeded with care while the resident was exhibiting responsive behaviours. A specific approach to care as outlined in the resident's plan was not implemented, resulting in the injury.

Sources: Interviews with a ADOC, a Director of Care (DOC), Resident's care plan, investigation notes.