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
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Public Report

Report Issue Date: December 22, 2025

Inspection Number: 2025-1088-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Peterborough, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9, 11, 15, 16, 17, 18, 22, 2025
The inspection occurred offsite on the following date(s): December 10, 12, 19, 2025

The following intake(s) were inspected:

- Intake: #00161571 - Critical Incident Report (CIR) # 2572-000058-25 - Unwitnessed fall of a resident resulting fracture
- Intake: #00161884 - Complaint : concerns regarding discharge and improper care of a resident
- Intake: #00162159 - eCorrespondence: Anonymous complaint concerns regarding improper care related to a fall
- Intake: #00162750 - CIR #2572-000060-25 - Fall of a resident with fracture
- Intake: #00162789 - CIR #2572-000061-25 - Improper transferring/repositioning from a PSW resulting in possible injury
- Intake: #00163374 - CIR #2572-000063-25 - Physical abuse of a resident by staff
- Intake: #00163701 - CIR #2572-000065-25- Alleged verbal abuse of a resident by staff

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

Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Redsidents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.
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:
3. Every resident has the right to have their participation in decision-making respected.

A Resident's rights were not respected and promoted when two Personal Support Workers (PSW) did not follow clear instructions from the resident related to correct positioning required for a comfortable transfer from their mobility aid to their bed.

Sources: Critical Incident Report (CIR) # 2572-000061-25, resident's clinical records, observation of a transfer of resident, interviews with resident, PSW and Director of Care (DOC)

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 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 reported to the home that a PSW was too quick with care and too rough on a specific date. The resident reported they felt emotionally hurt at the time of the incident. which was confirmed in an interview. The alleged emotional abuse was substantiated and confirmed by the Director of Care (DOC). As a result the PSW was disciplined.

Sources: Critical Incident Report (CIR) #2572-000063-25, home's investigations notes, interview with resident and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident did not receive integrated and collaborative care from staff and others involved in the different aspects of care when recognition of uncharacteristic confusion was not followed up upon, when medications essential to managing a medical condition were refused and the physician was not informed of refusal and when bloodwork necessary for monitoring therapeutic response to medication was not collected. Assessments of these occurrences were not integrated and followed up upon.

Sources: Resident's clinical records, interviews with the Behavioural Services Ontario (BSO) Registered Practical Nurses (RPN) and home's Pharmacy Consultant.

WRITTEN NOTIFICATION: Reporting certain matters to director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A PSW did not immediately report an incident of alleged verbal abuse of a resident by another PSW. A Critical Incident Report (CIR) was submitted approximately one month after the alleged incident when the PSW reported the incident to the Director of Care

(DOC) – Quality.

Sources: Critical Incident Report (CIR) # 2572-000065-25, resident's clinical records, homes' internal investigation file.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to implement strategies to reduce or mitigate the risk of falls. Specifically, the home's Falls Prevention and Injury Reduction program directed the home to implement Universal Fall Prevention Strategies to be used across the home for resident's safety. Additional fall prevention strategies to reduce or mitigate falls for high-risk residents will be implemented to meet the needs of each individual resident.

A resident, identified as high risk for falls, experienced an unwitnessed fall in their room. Staff found the resident on the floor with the bed in a high position. The Falls Lead and an RN indicated that the expectation, also outlined in the resident's care plan, was that the bed remains locked in the lowest position whenever the resident was in bed and unattended. As a result of the fall, the resident sustained an injury.

Sources: CIR #2572-000060-25, interviews with falls lead and RN, resident's clinical record, home's internal investigation notes, home's Fall prevention and Injury Reduction program- Care9-P10, reviewed, June 9,2025.

WRITTEN NOTIFICATION: Medication management system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

A resident was not provided with safe medication management when the physician was not informed of their ongoing refusal of a specific medication. Effective drug therapy outcomes were not achieved for the resident when serum levels quantifying therapeutic concentrations were not measured as ordered by the physician and as indicated for safe and efficacious use.

Sources: resident's clinical records, home's Medication Management Policy - RC-16-01-07, interview with the Director of Care (DOC) and Behavioural Services Ontario (BSO) Registered Practical Nurse (RPN)