

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: April 17, 2026

Inspection Number: 2026-1088-0002

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): April 13-17, 2026.

The following intake(s) were inspected:

- An anonymous complaint regarding allegations of improper care.
- An intake related to a resident that sustained an injury following a fall.
- A complaint regarding allegations of improper care.
- An intake related to a medical condition that resulted in a resident being transferred to the hospital.
- An intake related to allegations of staff to resident to physical abuse.

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect

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Recreational and Social Activities
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.

A resident's plan of care indicated they required a fall's prevention measure. The fall's prevention measure was not in place for a brief period, and the resident had an unwitnessed fall.

Sources: A critical Incident (CI), a resident's clinical health records and an interview with staff.

WRITTEN NOTIFICATION: Foot care and nail care

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

Non-compliance with: O. Reg. 246/22, s. 39 (2)

Foot care and nail care

s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

Registered Practical Nurse (RPN) confirmed that a resident's personal care was not completed on a particular day. The Director of Care (DOC) confirmed that personal support workers (PSWs) only document when residents refuse personal care. The DOC also confirmed that there was no documentation of a refusal of personal care in the resident's clinical record.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident's plan of care was not followed when a PSW transferred the resident without a second staff member present.

Sources: A CI, internal investigation records and a resident's clinical health records.

WRITTEN NOTIFICATION: Laundry service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 95 (1) (a) (iv)

Laundry service

s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,

(a) procedures are developed and implemented to ensure that,

(iv) there is a process to report and locate residents' lost clothing and personal items;

The home did not follow the process for reporting and locating a resident's lost personal items. RPN confirmed that a resident's personal items were missing and that the RPN was unaware whether they had been found. RPN and the DOC acknowledged that there was no documentation in the clinical record regarding the resident's missing personal item.

Sources: A resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Administration of drugs

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

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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).

On a specific day, a resident experienced a medical episode and was transferred to the hospital for treatment. RPN did not follow the physician's directions to check the resident's vital signs or to administer a medication, as prescribed.

Sources: A CI, internal investigation records, a resident's clinical health records and an interview with the DOC.



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

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