

**Ministry of Long-Term Care**

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

**London District**

130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

## Public Report

**Report Issue Date:** September 11, 2025

**Inspection Number:** 2025-1175-0003

**Inspection Type:**

Critical Incident

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

**Long Term Care Home and City:** Extendicare Port Stanley, Port Stanley

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 9 - 11, 2025

The following intake was inspected:

- Intake: #00155066 - Critical Incident System (CIS): 2669-000003-25 - Related to resident care and support services

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

Resident Care and Support Services

## INSPECTION RESULTS

**WRITTEN NOTIFICATION: Plan of Care: Duty of licensee to comply with plan**

**Ministry of Long-Term Care**

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

**London District**

130 Dufferin Avenue, 4th Floor  
London, ON, N6A 5R2  
Telephone: (800) 663-3775

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.

The licensee has failed to ensure that a resident was provided care as per the resident's plan of care, when staff acknowledged that they did not provide care to the resident as per their plan of care.

**Sources:** Resident's electronic health care records and interviews with staff.

**WRITTEN NOTIFICATION: Plan of Care: Documentation**

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

**Non-compliance with: FLTCA, 2021, s. 6 (9) 1.**

Plan of care

s. 6 (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented accurately, when a staff member acknowledged their documentation did not reflect the level of care that was provided to the resident.

**Sources:** Resident's electronic health care records and interviews with staff.