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

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

Public Report

Report Issue Date: April 16, 2026

Inspection Number: 2026-1388-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Tecumseh, Tecumseh

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 7, 8, 9, 10, 13, 14, 15 and 16, 2026.

The following intake(s) were inspected:

- Intake: #00172608 - Critical Incident #2904-000013-26 Resident fall with injury.
- Intake: #00172914 - Critical Incident #2904-000014-26 Alleged abuse staff to resident.
- Intake: #00174873 - Critical Incident #2904-000018-26 Alleged improper/Incompetent care of a resident.
- Intake: #00175112 - Critical Incident #2904-000020-26 Improper/Incompetent treatment of a resident by staff.
- Intake: #00175694 - Critical Incident #2904-000024-26 Alleged improper/Incompetent care of a resident by staff.
- Intake: #00172950 - Complaint related to care and services.
- Intake: #00174798 - Complaint related to alleged neglect and care and services.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Prevention of Abuse and Neglect
Reporting and Complaints
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The written plan of care for a resident identified impaired communication with goals related to specific strategies to support the resident. The plan did not provide clear direction to staff and others who provide direct care to the resident related to the

specific strategy.

On April 14, 2026, a review of the written plan of care now identifies the specific strategy to enhance the resident's communication.

Sources: interview with staff, review of clinical records.

Date Remedy Implemented: April 14, 2026

WRITTEN NOTIFICATION: Skin and wound

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A resident was observed with a specific intervention in place. There was no documentation to support the utilization of this intervention, as acknowledged by staff during an interview.

Sources: resident's clinical record, interviews with staff

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

Plan of care
s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

A resident was observed using a specific device that was included in their plan of care. Staff confirmed that the resident should have undergone an assessment related to the use the device, however no such assessment was documented.

Sources: observations, resident's clinical record and interviews with staff

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 dietary plan of care specified that a certain item was not to be provided at any meals. Despite this, the item was observed as being served to resident. Staff confirmed that the resident should not have been served the item.

Sources: resident's dietary plan of care and interview with staff

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #005 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.

Care set out in a resident's plan of care was not provided to the resident as specified in the plan when staff did not implement a specific intervention.

Sources: interviews with staff, clinical record review, video surveillance review.

WRITTEN NOTIFICATION: Plan of Care

NC #006 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.

A resident's care plan indicated a specific intervention, however the resident's clinical record did not contain any information to support the documentation of care provided related to this intervention. Staff confirmed that there was no task assigned in Point of Care to support the care set out in the care plan.

Sources: resident's clinical record and interviews with the staff

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A staff member did not safely provide a resident with an afternoon snack, leaving it out of the resident's reach and did not offer assistance/supervision as per the resident's plan of care.

Sources: staff interviews, clinical record review, video surveillance review.

WRITTEN NOTIFICATION: Dealing with complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

A verbal complaint was received related to an incident that had occurred with a resident. The home indicated that the follow up and investigation extended past 10 business days and it was found that the complainant was not made aware of any

time frame of when they could expect a resolution.

Sources: interviews with staff, clinical record review, review of Policy and Procedure and the home's Complainant Investigation Form.

WRITTEN NOTIFICATION: Administration of Drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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).

The physician wrote an order to hold a resident's medication and to review after a specific date to restart. The medication was never reviewed or restarted following this date, as ordered.

Sources: a resident's clinical records, Long-Term Care homes investigation file