

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

North District  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Public Report

**Report Issue Date:** February 20, 2026

**Inspection Number:** 2026-1472-0001

**Inspection Type:**  
Critical Incident

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

**Long Term Care Home and City:** Extendicare Timmins, Timmins

## INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 17-20, 2026

The following intakes were inspected:

- Two intakes regarding falls with residents resulting in injury
- One intake regarding allegations of verbal abuse/improper care of a resident

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

Prevention of Abuse and Neglect  
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 (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 had multiple falls on specific dates. Staff indicated that universal falls

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prevention strategies were in place at the time of the falls, however the resident's care plan did not include the intervention.

Sources: A resident's care plan, the licensee's Fall Prevention Program policy; and interviews with staff.

### **WRITTEN NOTIFICATION: Plan of care**

NC #002 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 did not receive the care as outlined in their plan of care on a specific date.

Sources: A resident's careplan and interviews with a staff and a Director of Care (DOC).

### **WRITTEN NOTIFICATION: Policy to promote zero tolerance**

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

#### **Non-compliance with: FLTCA, 2021, s. 25 (1)**

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The home's zero tolerance policies for abuse and neglect were not followed on a specific date when allegations of verbal abuse toward a resident by a staff member were made.

Sources: Critical Incident Submission (CIS) report, the licensee's policies on zero tolerance of abuse and neglect, and a resident's progress notes; and interviews with a staff and a DOC.

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## WRITTEN NOTIFICATION: Report 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.

An incident of alleged verbal abuse of a resident by a staff member was not immediately reported to the Director.

Sources: CIS report, the licensee's policies regarding zero tolerance of abuse and neglect, and a resident's health record; and interviews with staff and a DOC.

## 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 was required to ensure that there was a falls prevention and management program in place and that it was complied with.

A resident had multiple falls. The home did not follow their falls prevention and management program after the falls had occurred.

Sources: A resident's electronic health record, the licensee's fall prevention and injury reduction program; and interviews with staff.

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## WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

### Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

Notification re incidents

s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The Substitute decision-maker (SDM) was not immediately notified by the home of allegations of verbal abuse of a resident.

Sources: CIS report, the licensee's policy for immediate response and mandatory reporting of abuse or neglect, a resident's progress notes, and interviews with the DOCs.



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

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