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 17, 2025
Inspection Number: 2025-1409-0008
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Port Hope, Port Hope

INSPECTION SUMMARY

The inspection occurred on site on the following dates: December 9-12 and 15-17, 2025, with December 10 conducted off-site.

The following intakes were completed in this complaint inspection:
-A complaint related to integration of assessments, care;
-A complaint related to personal items and personal aids.

The following intakes were completed in this Critical Incident (CI) inspection:
-Two intakes related to falls prevention and management;
-An intake related to loss of essential services.

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

Housekeeping, Laundry and Maintenance Services
Reporting and Complaints
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) (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

Direct care staff were not provided clear direction regarding a specific care intervention for a resident who required assistance.

Sources: Resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 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

The home did not collaborate with the health care team to ensure that a resident had integrated care.

Sources: Complaint, resident's health records, interviews with staff.

WRITTEN NOTIFICATION: Documentation

NC #003 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 did not ensure documentation of care in the plan of care for a specific care intervention for a resident.

Sources: Resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A resident did not receive a bath, shower or bed bath twice weekly.

Sources: Anonymous complaint, resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (2)
Personal items and personal aids
s. 41 (2) The licensee shall ensure that each resident receives assistance, if required, to use personal aids.

The home provided a resident assistance with personal aids nineteen out of seventy-six days. The resident required assistance with their personal aids.

Sources: Anonymous complaint, resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Maintenance services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents

is maintained at a temperature of at least 40 degrees Celsius;

The water temperatures documented on the bath temperature records for a resident home area did not consistently meet the required temperature of at least 40 degrees Celsius. On several dates over a period of three months, there were documented temperatures below 40 degrees Celsius, with no documentation to indicate if the Registered Nurse was notified or if any steps were taken to achieve the required minimum temperature. There were also several day and afternoon shifts with no temperature documented on the records (left blank).

Sources: The LTC home's bath temperature records, interview with staff.

WRITTEN NOTIFICATION: Maintenance services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

The water temperatures were not monitored once per shift, as required, in random locations where residents have access to hot water. Water temperature logs provided by the LTC home for a period of three months were incomplete and many of the documented water temperatures were measured in areas not accessed by residents.

Sources: LTC home's Water Temperature Logs, interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the

incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The Director was not informed within one business day of an incident which resulted in a significant change in a resident's health condition.

Sources: Critical Incident Report, resident's clinical records; interview with staff.