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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: May 28, 2025
Inspection Number: 2025-1323-0002
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 22, 23, 26, 27, 28, 2025

The following intake(s) were inspected:

- Intake: #00143491 - Fall of resident with fracture
- Intake: #00145227 - Neglect of residents by staff

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

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

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect multiple residents from neglect by a staff member when they did not receive continence care on a specific date.

Sources : Critical Incident Report (CIR) , home's internal investigation file , review of clinical records for nine residents, interview with DOC

WRITTEN NOTIFICATION: Care conference

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee failed to ensure that an annual care conference of the interdisciplinary team providing a resident's care was completed in 2024 to discuss the plan of care and any other matters of importance to the resident.

Sources : CIR, resident's clinical record, interviews with RN and DOC

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