

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: January 30, 2026
Inspection Number: 2026-1323-0001
Inspection Type: Critical Incident Follow up
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): January 22, 23, 27- 30, 2026
The inspection occurred offsite on the following date(s): January 26, 27, 2026

The following intake(s) were inspected:

- An intake related to a outbreak.
- An intake related to a fall incident of a resident.
- An intake related to a compliance order for Dining and Snack Services.
- An intake related to a compliance order for Nutritional and Hydration.
- An intake related to a compliance order for Dealing with Complaints.
- An intake related to a compliance order for Duty to Protect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

- Order #001 from Inspection #2025-1323-0004 related to FLTCA, 2021, s. 24 (1)
- Order #002 from Inspection #2025-1323-0004 related to O. Reg. 246/22, s. 74 (2) (c)
- Order #003 from Inspection #2025-1323-0004 related to O. Reg. 246/22, s. 79 (1) 5.
- Order #004 from Inspection #2025-1323-0004 related to O. Reg. 246/22, s. 108

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

Food, Nutrition and Hydration

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Infection Prevention and Control
Prevention of Abuse and Neglect
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

Resident's written plan of care indicated they required the physical assistance of one staff member for transfers. However, a physiotherapy assessment completed identified the resident as requiring a two person physical assist for transfers.

Sources: Critical Incident Report (CIR), resident's clinical record, and interview with staff.

WRITTEN NOTIFICATION: When reassessment, revision is required

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary;
or

The resident exhibited symptoms that indicated a potential change in health status prior to the fall incident. Despite these observable changes, the home did not complete or

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document a timely reassessment of the resident as required.

Sources: CIR, resident's clinical health records, and interview with staff.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The Falls Prevention and Management Program was not followed to reduce the incidence of falls and the risk of injury for a resident. In accordance with O. Reg 246/22, s. 11 (1) (b), the long - term care home was required to complete a fall risk assessment of a resident on a specific day. The resident experienced a fall incident on a later date. Per the coroner's determination, the fall was established as the cause of death.

Sources: CIR, resident's clinical health records, and interview with staff.



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

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