

# 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

#### **Hamilton District**

119 King Street West, 11th Floor Hamilton, ON, L8P 4Y7 Telephone: (800) 461-7137

## **Public Report**

Report Issue Date: June 27, 2025

**Inspection Number:** 2025-1369-0005

**Inspection Type:** Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Mississauga, Mississauga

## **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): June 19-20, 23-27, 2025

The following intake(s) were inspected:

• Intake # 00146984- CIS# 2884-000015-25, related to resident care and support services.

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

Resident Care and Support Services Housekeeping, Laundry and Maintenance Services

## **INSPECTION RESULTS**

### **WRITTEN NOTIFICATION: Plan of Care**

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.



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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 licensee failed to ensure the resident's plan of care was updated following an assessment, which indicated there were changes to the resident's specialized device.

Sources: Resident's clinical files; Interviews with staff.

# WRITTEN NOTIFICATION: Transferring and Positioning Techniques

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

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure the resident was transferred safely using safe transfer and positioning techniques, which resulted in the resident falling during a transfer.

**Sources**: Extendicare Mississauga Internal Investigation and Analysis Records; Interviews with staff; Extendicare Safe Lift and Transfer Policy.



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## **WRITTEN NOTIFICATION: Falls Prevention and Management**

NC #003 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).

The licensee has failed to comply with the home's Falls Prevention and Management Policy when the resident was immediately moved prior to being assessed by registered staff following a fall.

In accordance with Ontario Regulation 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and procedures developed for the Falls Prevention and Management Program were complied with. Specifically, the home did not comply with the post fall management section of the policy which stated the resident was to be assessed by a nurse prior to attempting to assist the resident to ambulate and/or transfer post fall, when the resident was moved prior to being assessed by registered staff.

**Sources**: Extendicare Mississauga Falls Prevention and Management Program Policy, reviewed June 2025; Progress notes; Interviews with staff.