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: August 1, 2025

Inspection Number: 2025-1088-0004

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Peterborough, Peterborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 22 - 24, 28 - 31, 2025
The following intake(s) were inspected:
-An intake for outbreak.
-Two intakes of allegations of abuse.
-Two fall intakes.

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 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 licensee failed to update the plan of care for a resident when their care plan needs changed.

The plan of care for a resident had been updated to indicate they require an assistive device, but also directed staff to use a different assistive device and that the resident can perform daily activities independently and that they require a fall prevention intervention at all times.

Two staff members acknowledged these are no longer required and the plan of care should be updated.

Sources: Observations, the resident's clinical health records and interviews with staff.

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that doors to multiple non-resident areas were closed and locked when unattended.

Specifically, doors to the tub/shower room, storage/PPE room, laundry room and servery areas were observed left open, unlocked and unattended and obtaining items that posed a potential risk to residents of the home.

Sources: Observations, interview with staff.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 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.

1.The licensee failed to ensure the safe and proper transfer assistance of a resident by failing to ensure that assistive equipment was utilized on their assistive device during transporting for a meal.

Sources: Observations, resident clinical health records, interview with staff.

2.The licensee failed to ensure that staff use safe transferring techniques resulting in a resident falling and sustaining significant injuries. Specifically, staff failed to follow the plan of care for two persons to provide assistance for transfer.

Sources: Home's investigation notes, the resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Continence and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

The licensee failed to ensure that a resident received assistance from staff for a personal care task, when a resident fell and sustained injuries requiring a transfer to hospital.

Staff indicated the resident's plan of care directs that they are not safe to be left unattended and they require two staff for their personal care needs. The Quality Director of Care acknowledged staff did not follow the plan of care resulting in the resident falling and receiving significant injuries.

Sources: Home's investigation notes, resident's clinical health records, interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control

program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 9.1 (f) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that Additional Personal Protective Equipment (PPE) requirements were complied with, including appropriate selection application, removal and disposal.

Specifically, when staff failed to wear Personal Protective Equipment (PPE) when in contact with a resident who was on Additional precautions.

Sources: Observations, a home Policy, resident s clinical health records, interviews with staff.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe

and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee is ordered to:
1. Provide education to all housekeeping staff on environmental safety including the avoidance of mopping of floors in resident rooms while residents are present whenever possible and when not possible to arrange for supervision of vulnerable residents until the floor is dry and the risk of falls is passed.
2. Provide education to all housekeeping and environmental staff on resident vulnerabilities and fall risks including common conditions that increase fall risk such as cognitive impairment, sensory impairment and impaired mobility; in addition strategies to recognize and mitigate environmental risks such safe procedures for wet floors, transportation of laundry carts and other housekeeping and environmental job tasks in resident areas.
3. Develop a written process to communicate to environmental staff to identify residents with high risk of falls and cognitive impairment they can utilize to recognize and mitigate environmental risks.
4. The licensee shall maintain records of attendance including name of staff who attended, date staff were trained, who trained staff, and training materials provided. Staff are to sign an acknowledgement of receiving training.
5. Keep a copy of the written process and attendance records detailed above and provide to Inspectors upon their request.

Grounds

1.The licensee failed to ensure that the home provided for the safety and security of a resident when staff mopped the floor while the resident was in the room. As a result, a resident fell and sustained an injury.

Staff indicated they mopped the floor in a resident's room while the resident was in the room. Staff acknowledged they told the resident that the floor was wet but did not think the resident heard them, and that the resident could likely not see the wet floor sign at the door.

The failure to mitigate an environmental hazard and ensure appropriate supervision resulted in significant injuries to a resident.

Sources: Observations, home's investigation notes, resident 's clinical health records, interviews with staff.

2.The licensee failed to ensure the safety and security of a resident when staff, while delivering linen, struck a resident with a laundry cart resulting in significant injuries.

The Environmental Services Manager (ESM) indicated the home has a process for having two staff deliver laundry, and if not possible that staff pull the cart from in front. The ESM acknowledged that staff did not follow the process and pushed the cart from behind obstructing their view causing them to strike a resident with the cart.

Failing to provide adequate safety precautions and awareness during laundry delivery resulted in a failure to protect a resident from avoidable harm and injury.

Sources: Video surveillance observation, home's investigation notes, resident 's clinical health records, interview with staff,

This order must be complied with by October 24, 2025

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.