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 West District
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Public Report

Report Issue Date: November 25, 2025
Inspection Number: 2025-1377-0007
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Halton Hills, Georgetown

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: November 18-21, 24-25, 2025.

The following Critical Incident (CI) intakes were inspected:
-Intake: #00159429 related to resident care and support services.
-Intake: #00160067 related to prevention of abuse and neglect.
-Intake: #00162224 related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident's written plan of care directed the staff to ensure their call bell was within easy reach. During an Inspector's observation, the resident was in their bedroom, and their call bell was not within their reach.

A Personal Support Worker (PSW) attended to the resident and placed the call bell in their hand.

Sources: Resident's written plan of care; Inspector's observations; Interviews with the resident and PSW.

Date Remedy Implemented: November 20, 2025

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.

On one occasion, two staff members did not use safe transferring techniques when they assisted a resident.

Sources: CI report and resident's clinical records; Interviews with staff and the Director of Care (DOC).

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A resident's responsive behaviours were being monitored using the home's Dementia Observation System (DOS).

The documentation on the DOS data collection sheet, and the background, analysis and planning section of the DOS worksheets were not completed. There were also no progress notes indicating the summary of the data collected through the DOS

charting.

Sources: Resident's DOS, progress notes; Interviews with the Behavioural Support Ontario (BSO) Assistant, and the DOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A resident had a physician's order for a medication to be given by mouth daily when needed. On four different dates, the as needed medication was given to the resident more than once daily.

Sources: Resident's physician orders, Medication Audit Report; Interviews with a Registered Practical Nurse (RPN), and other staff.