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

Hamilton District
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Public Report

Report Issue Date: October 29, 2025
Inspection Number: 2025-1343-0005
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Hamilton, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 27-29, 2025

The following intakes were inspected in this Critical Incident (CI) inspection:
-Intake #00156169/CI #2858-000029-25 and intake #00159244/CI #2858-000033-25 related to infection prevention and control

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with.

In accordance with Additional Requirement 9.1 (f), Additional Precautions, under the IPAC Standard for Long-Term Care Homes (April 2022, Revised September 2023), the licensee has failed to ensure that two staff members appropriately selected personal protective equipment (PPE) when only gloves were worn when providing care for a resident, who required contact precautions.

Sources: observation, resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure the Director was immediately informed, when an outbreak was reported to the Director two days after it was declared.

Sources: Critical incident report, email communication records with Hamilton Public Health Unit and IPAC Lead, policy: Extendicare Hamilton COVID-19 Outbreak Plan, interview with IPAC Lead.