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: August 21, 2025
Inspection Number: 2025-1369-0007
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): August 15, 18, 19, 20, 21, 2025

The following intake (s) were inspected:
-Intake: #00148182 - [Critical Incident (CI): 2884-000017-25] related to Infection Prevention and Control.
-Intake: #00153505 - [CI: 2884-000018-25] related to Prevention of Abuse and Neglect.
-Intake: #00153900 - [CI: 2884-000020-25] related to Resident Care and Support Services.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (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.

The licensee has failed to ensure that a resident was transferred as per their plan of care which was acknowledged by staff.

Sources: Critical Incident Report, a **resident's clinical records, the home's internal investigation notes, and staff interview.**

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 has failed to ensure that staff used safe transferring techniques when transferring a resident who required the assistance of two persons.

Sources: Critical Incident Report, the resident's care plan and the home's internal investigation notes.

WRITTEN NOTIFICATION: Infection prevention and control

NC #003 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).

A. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented and followed as per section 9.1 (f) which specified that additional precautions shall include

PPE requirements including appropriate selection application, removal and disposal of personal protective equipment (PPE).

On a specified date staff did not wear the appropriate PPE at the point of entry when supporting residents.

Sources: Staff observations, and additional precaution signage.

B. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated September 2023 was complied with in relation to Routine Practices under section 9. 1 (b).

On a specified date staff did not perform hand hygiene prior to entering two residents rooms.

Sources: Staff observations, additional precaution signage and the home's hand hygiene policy.