

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: October 16, 2025

Inspection Number: 2025-1369-0009

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): October 7, 8, 9, 10, 14 and 16, 2025

The following intake(s) were inspected:

- Intake #00156369 - Critical Incident (CI) #2884-000026-25 was related to Resident Care and Support Services.
- Intake #00156370 - Critical Incident (CI) #2884-000027-25 was related to Resident Care and Support Services.
- Intake #00158273 - Critical Incident (CI) #2884-000030-25 was related to Falls Prevention and Management.

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

Resident Care and Support Services
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

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Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

A). The licensee failed to ensure that an allegation of improper care or incompetent treatment toward a resident was immediately reported to the Director. Although two staff members became aware of the incident, the Director was not informed until the following day.

Pursuant to 154 (3) of the FLTCA 2021, the licensee is vicariously liable to staff members failing to comply with section 28 (1).

Sources: Critical Incident Report and the home's investigation notes.

B). The licensee failed to ensure that the Director was immediately informed upon becoming aware of an allegation of improper care or incompetent treatment toward a resident on a day in August.

The Director was not notified of the alleged incident until eleven hours later.

Sources: Critical Incident Report.

WRITTEN NOTIFICATION: Required programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee failed to comply with their Pain Management Policy when a resident sustained an unwitnessed bruise. According to the policy, routine pain management

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screening is required when a resident experiences new or worsened skin and wound integrity. However, routine screening was not completed on the day the resident sustained the bruise.

Sources: The home's Pain Management Policy and resident's progress notes.

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that resident who was exhibiting altered area of skin integrity received immediate treatment and timely interventions to promote healing and prevent infection as per their Skin and Wound Policy, which states that when a resident sustained an altered area of skin integrity, skin care strategies should be implemented in a timely manner to prevent skin breakdown.

In accordance with O. Reg. 246/22, s. 11(1)(b), the licensee was required to ensure that the home's policy was complied with.

Resident did not receive treatment and interventions for their affected skin area until one day later.

Sources: The home's Skin and Wound Policy and the resident's clinical records, including progress notes.