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: October 1, 2025
Inspection Number: 2025-1071-0007
Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Oshawa, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18 -19, 22 - 26, 29, and October 1, 2025

The following intake(s) were inspected in this Follow-up (FU) inspection:
One Follow-up related to O. Reg. 246/22 - s. 58 (4) (c) Responsive Behaviour, CDD September 9, 2025
One Follow-up related to O. Reg. 246/22 - s. 93 (2) (a) (i) Housekeeping, CDD September 9, 2025

The following intake(s) were inspected in this Critical Incident (CI) inspection:
One intake related to resident abuse

The following intake(s) were inspected in this complaint inspection:
One intake related to neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1071-0005 related to O. Reg. 246/22, s. 58 (4) (c)
Order #001 from Inspection #2025-1071-0006 related to O. Reg. 246/22, s. 93 (2) (a) (i)

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

Housekeeping, Laundry and Maintenance Services
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.

The licensee did not promptly investigate or take appropriate actions when a suspected case of physical abuse was reported to the licensee.

On a specific date, the licensee was notified about a suspected skin integrity issue of a resident. The licensee failed to complete the clinical assessments and report the incident to the police.

Source: Home's investigation notes, resident's medical records, and interviews with staff

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