

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: February 20, 2026
Inspection Number: 2026-1071-0002
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Oshawa, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 17 - 20, 2026

The following intake(s) were inspected:

- Intake: #00167631 - Outbreak
- Intake: #00167635 - Improper care of resident

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be treated with respect

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual

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orientation, gender identity, gender expression, age, marital status, family status or disability.

On a specified date a staff did not provide dignified care to a resident.

Sources: Critical Incident Report (CIR), resident clinical records, Home's Policy and interviews with staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

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

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

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.

An allegation of staff to resident improper care was not immediately reported to the Director when staff became aware that another staff did not provide dignified care to a resident.

Sources: CIR, Home's investigation file and interview with staff.

WRITTEN NOTIFICATION: CMOH and MOH

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

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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During a record review it was noted self assessment audits were not conducted weekly when in outbreak as recommended. Interview with staff confirmed weekly audits were not completed.

Sources: Review of the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings and interview with staff.



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**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

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