

**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:** November 24, 2025

**Inspection Number:** 2025-1064-0006

**Inspection Type:**

Critical Incident

**Licensee:** Extendicare (Canada) Inc.

**Long Term Care Home and City:** Extendicare St. Catharines, St Catharines

**INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): November 17, 18, 19, 20, 21, 24, 2025.

The following intake(s) were inspected:

-Intake: #00159402 - Critical Incident (CI) #2321-000037-25 - related to resident care and support services and responsive behaviours.

-Intake: #00159905 - CI #2321-000039-25 -related to falls prevention and management.

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

- Resident Care and Support Services
- Responsive Behaviours
- Falls Prevention and Management

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## INSPECTION RESULTS

### Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

**Non-compliance with: FLTCA, 2021, s. 6 (10) (b)**

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,  
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

During care, a resident sustained an injury. Their plan of care had not been revised to provide updated direction to staff for this care. This was remedied when the home reviewed and revised their plan of care.

**Sources:** critical incident report, a resident's care plan, tasks, interview with staff.

### WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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.

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During care, a resident sustained an injury. Their plan of care required a specific number of staff to be present when this care was being provided. The specified number of staff had not been present.

**Source:** critical incident, home's investigative notes, a resident's care plan, and interviews with staff.

## **WRITTEN NOTIFICATION: Compliance with manufacturers' instructions**

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

**Non-compliance with: O. Reg. 246/22, s. 26**

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

A resident sustained an injury while using specific equipment. Manufacturers' instructions for use of the equipment were not located in the area that the equipment was used and not available in the home at the onset of the inspection.

Instructions obtained during the inspection indicated use of the equipment with additions may prevent this type of incident from occurring. The additions were confirmed to not be in place at the time of use.

**Sources:** critical incident, manufacturers' description of the equipment, interviews with staff.

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## WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)**

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

During care, a resident sustained an injury.

Their plan of care identified that prior to starting care, a specific intervention was to be provided to them. An interview with staff indicated the intervention had not been provided.

**Sources:** critical incident, a resident's care plan, interview with a staff.