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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: March 11, 2026
Inspection Number: 2026-1064-0001
Inspection Type: Proactive Compliance Inspection
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): February 25-27 and March 2-5, 9-11, 2026.

The inspection occurred offsite on the following date(s): March 6, 2026.

The following intake(s) were inspected:
-Intake: #00171425 - Proactive Compliance Inspection (PCI).

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A resident's progress notes identified the resident was on heightened monitoring related to responsive behaviours.

Staff and others involved in the different aspects of the resident's care had completed assessments over time, that had not been integrated, consistent and had not complemented each other, in relation to their behaviours.

Sources: Resident progress notes; Confusion Assessment Method (CAM); Seniors Mental Health Outreach (SMHO) assessment and interviews with the Acting Assistant Director of Care (ADOC) and Responsive Behaviour program lead.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A resident's plan of care indicated they were to be positioned at a certain angle for nutritional interventions. Contrarily, it also indicated that the resident did not receive anything by mouth (NPO), and was to be positioned at a different angle for a nutritional intervention. Nursing staff and the Registered Dietitian (RD) did not collaborate with each other in the development of the resident's plan of care to ensure these aspects of care complemented each other.

Sources: Resident's plan of care, interview with RD.

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident's Substitute Decision Maker (SDM) was not given an opportunity to participate fully in the development and implementation of the resident's plan of care when they were not notified of potentially harmful interactions between the resident and another resident until a later date.

Sources: Resident progress notes, interviews with acting ADOC, Responsive Behaviour program lead and the resident's SDM.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks.

A resident had been a recipient of two potentially harmful interactions by another resident. The resident's clinical record had not contained any interdisciplinary assessments related to these interactions and as a result, their plan of care had not contained any goals, or interventions to address safety risks and ensure their ongoing safety.

Sources: Resident's progress notes and clinical records; interviews with acting ADOC and Responsive Behaviour program lead.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A resident's progress notes for two months in 2026 had indicated several instances where the resident demonstrated responsive behaviours. Documentation had not included any actions taken to respond to the needs of the resident, including assessments, reassessments, interventions, and the resident's response to interventions. The home's policy indicated the Behaviour Support Lead and team would conduct rounds for residents with responsive behaviours and would complete a Debrief following an incident that results in harm, injury or threat of injury and these were not completed for several of the instances.

Sources: Resident's progress notes; assessments; Policy; Behaviour Huddle; and interviews with acting ADOC and Responsive Behaviour program lead.

WRITTEN NOTIFICATION: Behaviours and altercations

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

A review of several procedures for the home's Responsive Behaviour Program and an interview with the program lead confirmed they were unable to locate these procedures and interventions at the time of the inspection.

Sources: Resident's progress notes; resident's clinical records and interviews with acting ADOC staff and Responsive Behaviour program lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The home experienced an enteric outbreak that was declared in February 2026 by Public Health. The home did not report the outbreak to the Director until four days later.

Sources: Critical Report 2321-000005-26, interview with Infection Prevention and Control (IPAC) Lead.