

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**North District**  
159 Cedar St, Suite 403  
Sudbury, ON, P3E 6A5  
Telephone: (800) 663-6965

## Public Report

<b>Report Issue Date:</b> September 11, 2025
<b>Inspection Number:</b> 2025-1115-0004
<b>Inspection Type:</b> Complaint Critical Incident Follow up
<b>Licensee:</b> Extendicare (Canada) Inc.
<b>Long Term Care Home and City:</b> Extendicare York, Sudbury

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 8-11, 2025

The following intake(s) were inspected:

- One Intake related to Environmental Hazard- breakdown of call bell system;
- One Complaint Intake related to concerns regarding call bell and resident neglect; and,
- One Intake for Follow-up #1 - CO #001 / 2025-1115-0003, FLTCA, 2021, s. 24 (1), Duty to Protect.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:  
Order #001 from Inspection #2025-1115-0003 related to FLTCA, 2021, s. 24 (1)

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

Resident Care and Support Services  
Safe and Secure Home  
Responsive Behaviours

## INSPECTION RESULTS

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## WRITTEN NOTIFICATION: Reports re Critical Incidents

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

**Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. ii.**

Reports re critical incidents

s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
  - ii. a breakdown of major equipment or a system in the home,

The licensee failed to ensure that the Director was informed of a call bell system failure no later than one business day.

Critical incident (CI) was submitted for a call bell system failure which occurred on a specified date; however, the Director was not made aware of this until the CI report was submitted a few days later.

**Sources:** Critical Incident Report, and DOC interview.

## WRITTEN NOTIFICATION: Emergency Plans

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

**Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. ix.**

Emergency plans

s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:

1. Dealing with emergencies, including, without being limited to,

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ix. loss of one or more essential services,

The licensee failed to comply with their emergency plans for dealing with emergencies, including, without being limited to, loss of one or more essential services. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written plans for dealing with loss of essential services were complied with. Specifically, the home's nurse call system policy indicated in the event that the Nurse Call System is not functioning due to power failure or the like, resident checks must be completed every 15 minutes, and documented, until there has been a restoration of power and/or functioning of the system.

Upon review of the Fire Safety Visual Investigation Check Off List there were several times where documentation was missing on the checklist.

Sources: Fire Safety Visual Investigation Check Off List, home's policy titles "Nurse Call System, RC-08-01-01, last reviewed June 2025, Critical Incident Report, Interviews with staff, Environmental Services Manager, and the Director of Care (DOC).



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

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