Ontario

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

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

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

Original Public Report

Report Issue Date: October 31, 2024
Inspection Number: 2024-1120-0005
Inspection Type:
Complaint
Critical Incident
Follow up

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 29-30, 2024

The following intakes were inspected:
- Two follow-up intakes related to the infection prevention and control program
- One follow-up intake related to the Chief Medical Officer of Health and Medical Officer of Health
- One complaint related to concerns of neglect of a resident
- One intake related to neglect of a resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #003 from Inspection #2024-1120-0004 related to O. Reg. 246/22, s. 272

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Order #001 from Inspection #2024-1120-0004 related to O. Reg. 246/22, s. 102 (2) (b)
Order #002 from Inspection #2024-1120-0004 related to O. Reg. 246/22, s. 102 (11)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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.

The licensee has failed to ensure that a specific care activity for a resident was completed as specified in their plan of care.

A staff member stated that a care activity for a resident was not completed as required.

Sources: A critical incident submission (CIS); a resident's care plan; and an interview with a staff member and the Administrator.

WRITTEN NOTIFICATION: Reports of investigation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of an alleged neglect investigation were reported to the Director.

Sources: A CIS and an interview with the Administrator.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
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:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that reasonable grounds to suspect neglect were immediately reported to the Director.

An incident of possible neglect was reported to the home on a specific date; however, the Director was not notified of the incident until three days later.

Sources: A CIS and an interview with the Administrator.

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 250 (1) 4.
Director of Nursing and Personal Care
s. 250 (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.

The licensee has failed to ensure that the home had a Director of Nursing and Personal Care who worked regularly in that position on site for at least 24 hours per week, during a specified time period.

Sources: Email correspondence, and an interview with the Administrator.