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

North District
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Public Report

Report Issue Date: January 23, 2025
Inspection Number: 2025-1120-0001
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 20-22, 2025

The following intakes were inspected:

- One intake related to abuse of a resident
- One complaint intake related to concerns about care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

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

Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe environment for its residents.

Sources: Critical Incident Submission (CIS), and the licensee's policies; and interviews with the Administrator, and other staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) had the opportunity to fully participate in the development and implementation of the resident's plan of care.

Sources: A resident's electronic health record, the home's email correspondences, and the licensee's policy; and interviews with a resident's SDM, and registered staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 the care set out in a resident's plan of care for a specific assessment was provided over a specified period of time, as outlined in their plan of care.

Sources: A resident's electronic health record and the licensee's policy; and interviews with registered staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
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,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that after a specific incident occurred, a resident was reassessed and that their plan of care was reviewed and revised.

Sources: A resident's electronic health record; and interviews with the Administrator and other staff members.

WRITTEN NOTIFICATION: Duty to protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse.

Sources: CIS, a resident's electronic health record, and the home's investigation file; and interviews with a visitor and the Administrator.

WRITTEN NOTIFICATION: Orientation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 11.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that specific staff members who provided direct care to residents received the training required by Ontario Regulation 246/22 for a specific program before performing their duties.

Sources: The home's training records and email correspondences; and an interview with a registered staff member.