

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

Report Issue Date: November 27, 2025

Inspection Number: 2025-1120-0005

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 24-26, 2025.
The inspection occurred offsite on the following date(s): November 27, 2025.

The following intake(s) were inspected:

- Two intakes related to alleged neglect of residents; and,
- One intake related to a fall which caused an injury to the resident.

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

Resident Care and Support Services
Falls Prevention and Management

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 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident; and

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A resident's care plan was updated to include specific interventions intended to promote safety; however, another section of the plan outlined actions to be taken in response to certain behaviours that conflicted with the new intervention. The plan did not provide clear guidance on how staff were to ensure overall safety of the resident. [627]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 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.

A family member brought forth allegations of neglect of a resident. The allegations of neglect were reported to the Director two days after the family brought forth the concerns. [627]



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

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