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

Public Report

Report Issue Date: July 18, 2025
Inspection Number: 2025-1176-0002
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Kirkland Lake, Kirkland Lake

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 7-11, 2025.

The following three intakes were inspected:
-Two Critical Incident (CI) intakes related to allegations of staff to resident abuse, and
-One Complaint intake related to the care of residents and the operation of the home.

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

Resident Care and Support Services
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

1.The licensee has failed to ensure that a resident was treated with courtesy and respect during an interaction with a staff member.

Sources: A resident's health care records, interviews with multiple staff members.

2.The licensee has failed to ensure that a staff member treated a resident with courtesy and respect while providing care.

Sources: A CI report, a resident's medical file, and progress notes, the home's internal investigation, a staff member's personal file, interviews with the multiple staff members.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 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 failed to protect a resident from abuse by a staff member who provided care to the resident.

Sources: A CI report, the home's internal investigation, a staff member's personal file; policy titled, Zero Tolerance of Abuse and Neglect, last reviewed on March 25, 2025, interviews with multiple staff members.

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 failed to ensure that when a potential situation of abuse of a resident happened, that it was immediately reported to the Director.

Sources: A CI report, the home's investigation file on incident, a staff member's personal file, policy titled, Resident Safety Incident program last reviewed on March 25, 2025, interviews with multiple staff members.

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) 5.

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:

5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of the resident's identified responsive behaviours.

Sources: A resident's progress notes and plan of care report, the home's policy titled "Plan of Care" last reviewed June 2025, interview with a staff member.

WRITTEN NOTIFICATION: Director of Nursing and Personal Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 250 (3) (b)

Director of Nursing and Personal Care

s. 250 (3) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care,

(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and

The licensee has failed to ensure that the Director of Care (DOC) had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting before they began their employment with the home.

Sources: DOC offer of employment, interview with the DOC.

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