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: May 2, 2025

Inspection Number: 2025-1115-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare York, Sudbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 28, to May 2, 2025
The following intake(s) were inspected:

- An intake related to a medication incident.
- An intake related to the neglect of a resident.
- An intake related to an enteric outbreak.
- An intake related to a complaint regarding improper resident care.
- An intake related to the unexpected death of a resident.
- An intake related to a physical altercation between two residents.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

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 (1) 2.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee failed to ensure that the director was immediately informed of a resident who had an unexpected death.

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that the registered staff followed the homes

medication management system in the processing of a resident's medication orders.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that the medication management system is complied with.

A resident went an extended period without the required medications due to the home not following their medication management process.

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