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

Ottawa District
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Public Report

Report Issue Date: July 17, 2025
Inspection Number: 2025-1093-0005
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Medex, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8-11, 14-16, 2025

The following intake(s) were inspected:

- Intake: #00149163/CI #2579-000012-25 - related to improper/incompetent care of resident.
- Intake: #00150984 - related to a complaint regarding the use of a restraint.

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

Resident Care and Support Services
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident had a fall in the month of May 2025, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Sources: Fall prevention and management policy, resident's health records, interview with RN, RPNs, ADOC and DOC.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee has failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was dealt with. Specifically, when the Substitute Decision Maker (SDM) of a resident brought forward a complaint to a staff member about the safety of the resident after an incident, and the complaint was not investigated.

Source: Complaint Log binder, interview with DOC and ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition was reported to the Director. Specifically, when a resident had a fall that resulted in an injury and a significant change to their health condition and care needs, the incident was not reported to the Director.

Sources: MLTC reporting website, resident's health records, interview with RPNs, PSW and DOC.