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

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Public Report

Report Issue Date: January 28, 2025

Inspection Number: 2025-1323-0001

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kawartha Lakes, Lindsay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 to 24, 27 and 28, 2025.

The following intake(s) were inspected:

- Intake: #00122312 - improper care of a resident.
- Intake: #00125093 - neglect of a resident.
- Intake: #00125867 - resident fall with injury.
- Intake: #00132834 - resident to resident physical abuse.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Reporting and Complaints
Pain Management
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 (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 failed on two separate occasions to ensure that the care set out in the plan of care was provided to a resident, as specified in the plan.

On the first occasion, registered staff failed to re-attempt when a cognitively impaired resident refused a scheduled one-hour neurological assessment after an unwitnessed fall. The Falls Lead confirmed there was no documentation of re-attempts to complete the neurological assessment for the resident, as per the care plan.

On the second occasion, a Personal Support Worker (PSW) confirmed that a resident required a fall prevention device to be used for the resident when they were sitting up, but the PSW was unable to locate one before they got the resident up for the day.

Sources: resident observation, critical incident report, resident clinical records, staff interviews (Falls Lead and PSW).

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee failed to ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) were readily available at the home, when a resident was assisted into a sitting position without the use of the device. A personal support worker (PSW) confirmed that they did not have access to a new device from the physiotherapy supplies, on the day that they were unable to locate the device.

Sources: observation, PSW interview.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident with altered skin integrity received a skin assessment by an authorized person, upon any return of the resident from hospital. On the morning after a fall, prior to the resident's hospital transfer, a

progress note indicated that staff had observed altered skin integrity, and after returning from hospital later the same day, the night shift nurse documented an observation of a different area of altered skin integrity and included the approximate size. The home's policy entitled 'Skin and Wound Management' directed registered nursing staff to complete a comprehensive head-to-toe skin assessment when a resident returned from hospital, and the Falls Lead confirmed that this was not done.

Sources: resident clinical records, home's "Skin and Wound Management' policy, Falls Lead interview.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, received a skin assessment by an authorized person, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. After a residents unwitnessed fall, a registered nursing staff observed two areas of altered skin integrity, and on the next morning a different area of altered skin integrity was observed. The home's policy entitled 'Skin and Wound Management' directed

registered nursing staff to complete a comprehensive head-to-toe skin assessment when clinically indicated, such as a change in condition, and the Falls Lead confirmed that this was not done.

Sources: resident clinical records, home's 'Skin and Wound Management' policy, Falls Lead interview.

WRITTEN NOTIFICATION: Pain Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. An assessment of a resident's pain was not completed post fall when they were noted to be experiencing severe pain and expressing their discomfort audibly, prior to hospital transfer. Upon their return from hospital their pain began to increase overnight and by the next day they were audibly and physically expressing symptoms of pain, requiring hospitalization for treatment of unmanaged/undertreated pain, as per the physician's discharge summary. The Falls/Pain Lead confirmed that staff were expected to complete pain assessments when the resident had new pain after a fall, and upon return from hospital, and no assessments were done.

Sources: resident clinical records, physician's hospital discharge summary, Falls/Pain Lead interview.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Additional Requirement 7.3 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023) the licensee has failed to ensure that audits were performed regularly (at least quarterly) to ensure that all staff could perform the IPAC skills required of their role, as confirmed by the IPAC Lead.

Sources: 2024 IPAC audits, IPAC lead interview.

WRITTEN NOTIFICATION: Reporting and Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.
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:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

The licensee failed to ensure that the response to a complaint included an explanation of what had been done to resolve the complaint, when there was no long-term action plan provided to the complainant regarding their concern about prolonged response time for a resident.

Sources: critical incident report, resident clinical record, LTC home's Complaints and Customer Service policy, investigation file, Director of Care interview.