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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: April 3, 2025
Inspection Number: 2025-1328-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Lakefield, Lakefield

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20, 21, 24, 26-28, 2025 and April 1, 3, 2025

The inspection occurred offsite on the following date(s): April 2, 2025

The following intake(s) were inspected:

-two intakes - for allegation of resident to resident physical abuse
-one intake- for an allegation of improper care of a resident
-one intake- for an allegation of resident to resident sexual abuse
-one intake - for a complaint alleging neglect
-Follow-up #: 2 - O. Reg. 246/22 - s. 93 (2)
-one intake- for a complaint re: administration of medications

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #006 from Inspection #2024-1328-0003 related to O. Reg. 246/22, s. 93 (2)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

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 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure the provision of care set out in the resident's plan of care was recorded. Documentation to indicate the resident was provided continence care/assistance and repositioning was missing on a specified date, on day shift. Documentation for the amount of food and fluids the resident had consumed was missing on days and evenings.

Sources: the resident's clinical health records, and interview with the RPN.

WRITTEN NOTIFICATION: Protection from certain restraining

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 39 (4)
Common law duty
s. 39 (4) If a resident is being restrained by the administration of a drug pursuant to the common law duty referred to in subsection (1), the licensee shall ensure that the drug is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied.

As per Ontario Relation 246/22, s. 149 (2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 39 of the Act is documented, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. Circumstances precipitating the administration of the drug.
2. Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug.
3. The resident's response to the drug.
4. All assessments, reassessments and monitoring of the resident.
5. Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug.

The licensee failed to ensure documentation as per the regulations was completed. Documentation identified that the resident was known to exhibit responsive behaviours. On two identified dates, a medication that was considered a chemical restraint was administered by the RPN (Registered Practical Nurse). No

documentation was found to support why it was administered on both dates. No assessments before or after the medication was administered were found on both dates. The Director of Care (DOC) confirmed the medication was a chemical restraint and the RPN should have documented why the medication was given and was to assess the resident and document after the medication was given.

Sources: the resident's clinical health records and interview with DOC.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee failed to ensure their pain management program to identify pain in residents and manage pain was implemented for the resident.

The resident had new uncontrolled pain. New medication was initiated. The resident continued to have uncontrolled pain which impacted the staff's ability to provide care. The licensee's pain management program directs staff to complete a comprehensive pain assessment when a resident has new pain or new medication is started. The assessment is to be completed for a period of 72 hours when new medication is ordered. A comprehensive pain assessment was not found.

Sources: the licensee's policy, the resident's clinical health records and interview with the RPN.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that the RPN assessed, reassessed and the resident's response to the actions were documented. Documentation identified that the resident was known to exhibit responsive behaviours. A medication that was a chemical restraint was administered to the resident. No documentation was found to support why it was administered on both dates. No assessments before or after the medication was administered were found on both dates. The Director of Care confirmed the medication was a chemical restraint and the RPN should have documented what non-pharmacological interventions were tried before the medication was given and was to assess the resident and document after the medication was given.

Sources: the resident's clinical records, interview with the DOC.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every

medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee failed to ensure that every medication incident involving the resident, was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A medication was found at the resident's bedside. A medication incident report was not completed.

Sources: the resident's clinical health records, interview with DOC.

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake: #00141112 -Follow-up #: 2 - O. Reg. 246/22 - s. 93 (2) original CDD January 31, 2025

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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