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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Original Public Report

Report Issue Date: December 3, 2024
Inspection Number: 2024-1171-0009
Inspection Type: Complaint Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Laurier Manor, Gloucester

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 19 - 22, 2024 and November 25 - 29, 2024

The following intake(s) were inspected:

- Intake: #00121122, CIR #2665-000046-24, intake #00127533, CIR #2665-000056-24 and intake: #00129815, CIR #2665-000058-24 - related to alleged resident to resident abuse.
- Intake: #00121527, CIR #2665-000048-24 - related to injury resulting in a significant change in resident's condition.
- Intake: #00127883 - Follow-up #1 to Compliance Order (CO) #001 issued in inspection 2024-1171-0008, related to O. Reg. 246/22, s. 96 (2) (b) with a Compliance Due Date (CDD) of November 15, 2024.
- Intake: #00130380 - Complaint with concerns related to medication administration and environmental concerns.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1171-0008 related to O. Reg. 246/22, s. 96 (2) (b)

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), was given an opportunity to participate fully in the implementation of the resident's administration of a medication in 2024. In interviews, a Registered Nurse and the Director of Care (DOC) confirmed that the resident's SDM had not been contacted to participate in the implementation of this aspect of resident's plan of care.

Sources: resident's medication records, progress notes, care conference notes, other health records, and interviews with the Registered Nurse and DOC.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 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 has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan. Specifically, the plan of care of the resident indicated that they should have an intervention in place to provide privacy. During an observation, it was observed that this intervention was not in place. The Associate Director of Care (ADOC) confirmed that it is still an active intervention for the resident.

Sources: Resident's plan of care, interview with ADOC and observation.