

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 9, 2025

Inspection Number: 2025-1171-0001

Inspection Type:

Complaint

Critical Incident

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): January 3, 6, 8, 9, 2025

The following intake(s) were inspected:

- Intake: #00132368- Related to the fall of resident which resulted in a significant change in health status
- Intake: #00133642- Related to suspected resident to resident physical abuse
- Intake: #00134507- Complaint related to resident care and services

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Palliative Care
Pain Management
Falls Prevention and Management

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

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 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care is reviewed and revised when the resident's care needs change.

On a specific date a resident sustained a fall which resulted in an injury. The resident's plan of care was not revised until four days after the incident. A review of the resident's health record revealed as a result of the injury the resident's care needs had changed. When interviewed the Director of Care confirmed that the resident's plan of care should have been updated.

Source: Resident's health record, interview with the Director of Care.

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 (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

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to 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.

In accordance with O. Reg 246/22 s.11 (1) (b) the licensee is required to have policies as part of the Falls Prevention and Management Program and that they are complied with.

The licensee's Falls Prevention and Management Program policy directs the staff to complete a Fall Risk Assessment, for any fall with a serious injury.

On a specific date, a resident sustained a fall which resulted in an injury. A review of the resident's health record revealed no Fall Risk Assessment was completed. When interviewed the Director of Care confirmed that a Falls Risk Assessment should have been completed.

Source: Resident's health record, Extendicare Falls Prevention and Management policy RC-15-01-01 interview with the Director of Care.