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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 27, 2023
Original Report Issue Date: April 20, 2023
Inspection Number: 2023-1327-0004 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Southwood Lakes, Windsor

Amended By	**Inspector who Amended Digital Signature**
Samantha Perry (740)	Samantha Perry Digitally signed by Samantha Perry Date: 2023.05.15 08:50:58 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This report has been amended to reflect a change to NC #003 from O. Reg. 246/22, s. 55 (2) (b) (iii), to O. Reg. 246/22, s. 55 (2) (b) (iv).

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Lead Inspector Samantha Perry (740)	**Additional Inspector(s)**
Amended By Samantha Perry (740)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 23, 24, 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00002817 - Complaint related to safe and secure home.
- Intake: #00006476 – Complaint related to resident care concerns.
- Intake: #00007767 - CI: 2842-000026-22 related to resident responsive behaviours management.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: 001

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure there was a written plan of care specific to a resident's preferences, that set out the planned care for the resident.

The Ministry of Long-Term Care (MLTC) received multiple care concerns related to a resident.

A review of the resident's clinical records showed a plan was developed by several staff members, management and the resident's Power of Attorney (POA). Part of the plan documented the resident had specific preferences for their schedule and this was not documented as part of the plan of care.

Management said they were aware of the resident's schedule preferences as per the plan developed and this information should have been documented within the resident's plan of care and was not.

Sources: Resident clinical records and interviews with management. [740]

WRITTEN NOTIFICATION: 002

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report documenting an altercation between two residents, during which, one of the residents sustained an injury.

A review of the resident's clinical records documented the resident sustained an injury requiring a clinically appropriate skin and wound assessment to be completed by registered staff and the assessment was not completed.

Staff and management both said, when the resident sustained an injury, a skin and wound assessment should have been completed as legislated to decrease the resident's risk of altered skin integrity.

Sources: Resident clinical records, and interviews with staff and management. [740]

WRITTEN NOTIFICATION: 003

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident was reassessed at least weekly by a member of the registered nursing staff.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report documenting an altercation between two residents, during which, one of the residents sustained an injury.

A review of the resident's clinical records showed no documentation of any subsequent weekly skin and wound assessments to monitor the resident's injury.

Staff and management both said, subsequent weekly skin and wound assessments should have been completed for the resident to decrease their risk of altered skin integrity and were not.

Sources: Resident clinical records, and interviews with staff and management. [740]

WRITTEN NOTIFICATION: 004

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure the procedure to complete an assessment was implemented to assist the resident when they were harmed as a result of another resident's responsive behaviours.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System (CIS) report documenting an altercation between two residents, during which, one of the residents sustained an injury.

A review of the resident's clinical records showed no documentation of an assessment completed on the day of the altercation.

Staff and management both said, the resident assessments should have been started on the day of the altercation to decrease the resident's risk of any undiagnosed injuries and were not.

Sources: Resident clinical records, and interviews with staff and management. [740]

WRITTEN NOTIFICATION: 005

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee has failed to ensure the home provided a dining and snack service for a resident, that included, at a minimum the personal assistance and encouragement required for the resident to safely eat and drink as comfortably and independently as possible.

The Ministry of Long-Term Care (MLTC) received multiple care concerns related to a resident.

A review of the resident's clinical records documented the resident was to receive a specific type of assistance with meals. On several dates the resident did not receive the assistance required, as per their plan of care.

The home's management and multiple staff said a staff member should have been present in the resident's room to ensure the resident's safety while they ate their meal.

Sources: Resident plan of care, interviews with management and multiple staff members. [740]