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

# Original Public Report

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|---|---|
| **Report Issue Date:** June 12, 2023 | |
| **Inspection Number:** 2023-1327-0005 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident System | |
| **Licensee:** Extendicare (Canada) Inc. | |
| **Long Term Care Home and City:** Extendicare Southwood Lakes, Windsor | |
| **Lead Inspector**<br>Jennifer Bertolin (740915) | **Inspector Digital Signature**<br>Jennifer Bertolin Digitally signed by Jennifer Bertolin Date: 2023.06.12 14:46:16 -04'00' |
| **Additional Inspector(s)**<br>Julie D'Alessandro (739)<br>Adriana Congi (000751) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5 - 8, 2023
The inspection occurred offsite on the following date(s): June 7, 2023

The following intake(s) were inspected:

- Intake: #00001354 - [CI: 2842-000019-22]- Resident Care and Support Services
- Intake: #00011202 -[CI: 2842-000032-22] - Resident Care and Support Services
- Intake: #00012784 - [CI: 2842-000034-22] - Safe and Secure Home
- Intake: #00019083 -[CI:2842-000003-23]- Fall Prevention and Management
- Intake: #00022745 -[CI: 2842-000 [CI: 011-23] - Fall Prevention and Management
- Intake: #00085184 -[CI:2842-000013-23] : Fall Prevention and Management
- Intake: #00088422 -[IL-13441-AH / 2842-000020-23]- Fall Prevention and Management
- Intake: #00088812 -[IL-13594-LO] - Fall Prevention and Management
- Intake: #00088939 -[IL-13674-LO] -Fall Prevention and Management

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

Resident Care and Support Services
Infection Prevention and Control

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Late Reporting to the Director

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.

The licensee failed to ensure that the Director was immediately informed when a resident was missing for more than three hours.

**Rationale and Summary**

A review of the home's code yellow policy stated in part that, residents were considered missing when they were not in a location where staff could have found them, and they were not signed out of the home.

A resident left the Long-Term Care Home (LTCH), without following the LTCH's procedure for signing out.

A critical incident report (CIR) was not submitted by the LTCH as mandated by legislation. The Director of Care (DOC) acknowledged that the incident was not immediately reported and should have been.

The resident had not been impacted by the incident however, there was a moderate risk due to the potential that they could have been in a situation that jeopardized their safety or well-being while in the community.

**Sources:** CIR report; Code Yellow Policy (dated January 2023); Resident's progress notes; and interview with DOC.

[000751]