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
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: October 19, 2023	
Inspection Number: 2023-1327-0006	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Southwood Lakes, Windsor	
Lead Inspector Julie D'Alessandro (739)	**Inspector Digital Signature** Julie D'Alessandro Digitally signed by Julie D'Alessandro Date: 2023.10.24 10:28:53 -04'00'
Additional Inspector(s) Jennifer Bertolin (740915)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 11, 12, 13, and 18, 2023.

The following intake(s) were inspected:

- Intake: #00093559 /CI #2842-000029-23- related to falls prevention and management
- Intake: #00095492- complaint related to nutritional care and alleged neglect

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
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 (10) (b)

Introduction:
The licensee failed to ensure that a resident was reassessed and the plan of care revised when the resident's care needs changed.

Rationale and Summary:
A resident had a change in health status which was acknowledged during an interview with a staff member.

A review of the resident's clinical record did not indicate that an assessment had been completed or that the plan of care had been updated to reflect this change in health status. As a result of this change the resident required further intervention.

During an interview with the Director of Care (DOC) they acknowledged that an assessment should have been completed and the plan of care should have been revised for the resident but was not.

Sources: Resident's clinical chart and staff interviews.
[739]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

Introduction:
The licensee failed to ensure that the Substitute Decision Maker (SDM) of a resident was given the opportunity to participate in the development and implementation of the resident's plan of care.

Rationale and Summary:
A resident had a change in health status which was acknowledged during interviews with staff

members.

A review of the resident's progress notes had not shown that the SDM was notified of the change in care requirements. The resident required further intervention when they continued to have a decline in health status.

During an interview with the DOC they acknowledged that the SDM should have been notified of the change in the resident's care requirements, and was not.

Sources: Resident's clinical chart and staff interviews.
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