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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Original Public Report

Report Issue Date: December 4, 2024

Inspection Number: 2024-1327-0005

Inspection Type:
Complaint
Critical Incident
Follow Up.

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Southwood Lakes, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13-14, 18-19, 21-22, 25-27, 2024

The following intake(s) were inspected:

- Intake: #00125433 -related to a complaint regarding Housekeeping, Laundry & Maintenance Services, IPAC and Falls Prevention & Management.
- Intake: #00126076 -related to complaint regarding IPAC, Resident Care & Support Services, Medication Administration, Continence Care, and Food, Nutrition, & Hydration
- Intake: #00126955 -related to Resident Care & Support Services
- Intake: #00128724 - Follow-up #: 3 - FLTCA, 2021 - s. 19 (2) (a)
- Intake: #00130085 -related to complaint regarding Skin and Wound Care Prevention & Management
- Intake: #00131548 -related to Prevention of Abuse and Neglect

The following intake was completed in this inspection:

- Intake; #00132044-related to Prevention of Abuse and Neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1327-0001 related to FLTCA, 2021, s. 19 (2) (a)

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Response to Abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident.

The licensee failed to ensure that appropriate action was taken in response to an incident of alleged abuse.

Rationale and Summary:
A review of a resident's progress notes that documented an incident of alleged

abuse that took place between the resident and their visitor. This incident left an injury on the resident and no attempt to direct the visitor away from the resident was made. Following this incident, another incident occurred where the visitor reacted towards the resident. The witness, a staff member told the visitor that their actions were not acceptable, but the visitor was not asked to leave or separated from the resident. The visitor was permitted to accompany the resident back to their room.

In an interview completed with the staff member, they stated they knew the actions displayed by the visitor in response to the resident's behaviour were not acceptable, and after they witnessed these incidents they never attempted to separate the visitor from the resident.

A management team member, explained in an interview completed with them that it was the home's expectation that the staff member would have separated the visitor from the resident immediately after these incidents were witnessed. The management team member acknowledged that the visitor was not directed away from the resident or asked to leave when either of the instances of alleged abuse took place.

The resident sustained an injury as a result of this incident, and was left at risk when the home's staff failed to separate them from their abuser.

Sources: Progress notes for the resident, Interviews with a staff member and a management team member

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

The license failed to ensure that the staff participated in the implementation of the Infection Prevention and Control program (IPAC) in accordance with the IPAC Standard for Long-Term Care Homes (LTCHs).

Rationale and Summary:
The IPAC Standard for Long-Term care Homes (LTCHs) indicated under section 9.1 (b) routine practices shall include hand hygiene, including but not limited to at the four moments of hand hygiene and section 9.1 (d) the licensee should ensure that include the proper use of PPE including the appropriate selection application, removal, and disposal.

The Ministry of Long-Term Care (MLTC) had received a complaint regarding infection control practices related to a staff member assisting the resident. The complainant provided documentation that supported their complaint that infection control practices and guidelines were not being maintained while staff member assisted the resident.

During an observation on a specific date, the Inspector noted that a staff member did not maintain infection control practices while assisting the resident.

In an interview with a staff member, they reviewed the documentation provided by the complainant and were informed that the Inspector had observed another staff member assisting the resident without maintaining proper infection control practices. The staff member confirmed that staff are expected to adhere to and maintain routine practices as outlined in the Infection Prevention and Control (IPAC)

program and IPAC standards.

Failure to comply with IPAC and routine practices increases the risk of infection.

Sources: Documentation from the complainant, observations, and interview with staff member .

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that a drug administered to the resident was in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) had received a complaint alleging that the resident received two doses of a specific mediation on a specific date when only one dose was prescribed.

A review of the resident's medical orders in their hard copy chart revealed that, this specific medication was ordered to be administered at a specific time, then there was a new medical order written for this specific medication to be administered at a different time.

In interviews with two staff members, both confirmed that the resident received this specific medication twice on a specific day.

A management team member acknowledged that the medication was not administered according to the prescriber's order.

Failure to administer medication as prescribed puts the resident's health and well-being at risk.

Sources: Resident's Progress Notes; Interviews with staff members; Medical Orders for resident.