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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Public Report

Report Issue Date: July 2, 2025

Inspection Number: 2025-1327-0005

Inspection Type:
Complaint
Critical Incident

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): June 16-17, 19- 20, 23- 27, 2025 and July 2, 2025

The following intake(s) were inspected:

- Intake: #00147020- Complaint- related to supplies, lifts and transfers, staffing, maintenance, and air temperature
- Intake: #00147854-CI #2842-000013-25 – related to fall of resident
- Intake: #00148850 – Complaint- related to care of resident
- Intake: #00150576 -CI #2842-000021-25 - Improper/Incompetent treatment or care of a resident

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management

Safe and Secure Home
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Personal Support Worker (PSW) safely transferred a resident on an identified date. Interview with staff, who responded to the incident, confirmed that the PSW transferred the resident without a second person. The resident sustained an injury.

Sources: review of resident's progress notes, assessments, observation of resident in their room, interview with resident, interview with staff.

WRITTEN NOTIFICATION: Laundry Service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)
Laundry service
s. 95 (1) As part of the organized program of laundry services under clause 19 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

The licensee failed to ensure that sufficient supplies were always available on the home areas, for use by residents.

An observation made on an specific date of multiple home areas, identified there to be no care supplies or only a minimum available. Interviews with staff identified an insufficient amount of care supplies available on the home areas to provide care to residents throughout the entire shift. A resident stated they will often take a couple extra supplies in the morning because they are not sure if there will be more, and another resident stated that care is delayed when there are no supplies available.

Sources: Observations of home areas linen carts on a specific date, interviews with staff and residents.

WRITTEN NOTIFICATION: Reporting Complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to

the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to ensure that their acknowledgement of receipt to a written complaint from a resident's Power of Attorney, included an estimated date of the investigation completion. The home completed their investigation after 10 business days from the receipt of the complaint.

Sources: Complaint letter, Home's response letters, Critical incident, Investigation notes, Home's policy on complaints, Interview with the Executive Director.

WRITTEN NOTIFICATION: Reporting complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

The licensee has failed to ensure that the conclusion of the investigation with an explanation of what the licensee has done to resolve the complaint was communicated to the resident's Power of Attorney.
The home received a written complaint related to a resident 's care on an identified date and submitted a Critical Incident to the Director. The home conducted an investigation and sent a response letter to the complainant and to the Director, when the home finalized the Critical Incident. However, in the response letter, the home only indicated that an investigation was completed.

Sources: Complaint, Critical incident, Home's policy related to Complaints, interviews with Executive Director and Director of Care.

WRITTEN NOTIFICATION: Written records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that resident's written records were kept up to date at all times when a Personal Support Worker (PSW) documented the care of a resident, on a specific date, without providing care to the resident. In an interview with the Executive Director, it was stated that the PSW falsely documented the care that was not provided.

Sources: resident's care plan, Home's investigation notes, Home's policy on documentation, Complaint notes, interview with Executive Director