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

Public Report

Report Issue Date: December 19, 2025

Inspection Number: 2025-1327-0009

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 dates: December 9-12, 15-17, 19, 2025

The following intakes were inspected:

- Intake #00160508/ Critical Incident (CI) #2842-000044-25: relating to an allegation of abuse.
- Intake #00160518/ CI #2842-000045-25: relating to an allegation of improper care.
- Intake #00160694/ CI #2842-000046-25: relating to an allegation of neglect.
- Intake #00163057: relating to medication management and responsive behaviours.
- Intake #00163476: relating to safe and secure home.
- Intake #00163856: relating to multiple care concerns.
- Intake #00164657: relating to resident care and support services and skin and wound prevention and management.
- Intake #00164661: relating to responsive behaviours.

- Intake #00164834/ CI #2842-000056-25: relating to resident care and support services and skin and wound prevention and management.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The home did not immediately report three allegations of neglect. A staff indicated a resident refused their care several times. A registered staff indicated the resident was willing to receive their care but that the staff did not provide the care, even after being directed to do so. A staff confirmed this was reported late. The critical incident

report was completed four days after the incident.

Another resident rang their call bell and a staff turned it off indicating they would return but did not return. A staff member reported this incident to a registered staff. This was reported by the registered staff seven days after the incident, and the home then submitted the critical incident report.

A third resident alleged a staff turned off their call bell and left without speaking to them and later returned and provided care with improper technique. The staff that received the concern emailed the director of care and the administrator. The home reported the critical incident report three days later.

Sources: critical incident reports: #2842-000044-25, #2842-000045-25, #2842-000046-25, internal home email related to concern and interview with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The home received a complaint regarding care and did not investigate as required. A resident reported a care concern to the home. The home submitted this concern as a critical incident report. Staff stated no investigation was completed into the resident's allegation. The resident indicated no one from the home has followed up with them in regards to their reported complaint.

Sources: critical incident report #2842-000045-25 and interviews with staff and the resident.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

A resident was involved in a medication incident. The staff completed a medication incident report (MIR) but the home did not complete the home's MIR in full. As of result of not completing the MIR in full the incident was not reviewed and analyzed, corrective action was not taken, and a complete written record was not maintained.

Sources: Interview with staff, progress notes, and complainant notes.

COMPLIANCE ORDER CO #001 Administration of Drugs

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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. O. Reg. 246/22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Provide re-training to all registered nursing staff, including leadership staff who are registered nursing staff. The training includes, but not limited to, the current College of Nurses of Ontario (CNO) Practice Standard for Medication, and review of the home's Medication Administration policy, including the use of Medical Directives.
2. Complete weekly audits for the specified resident, reviewing the documentation and administration of medications found on the Medication Administration Record for a period of 6 weeks to ensure that drugs are administered in accordance with the directions for use, specified by the prescriber. The audits will include the date the audit was conducted, any deficiencies and follow up provided to the staff, and who completed the audit.
3. Maintain a written record of the requirements under (1) and (2). Documentation of education shall include the names of the staff, their designation, the date training

was provided, the name of who provided the training, and a copy of training materials and documents utilized.

Grounds
Introduction

A resident did not have a medical directive administered and another resident did not have two medication administered, in accordance with the directions for use specified by the prescriber.

The first resident was presenting with symptoms. The resident had a Medical Directive ordered in place for medication to be administered for the same symptoms, the medication was not administered during the medical event. A staff identified that the medication should have been administered to the resident as ordered.

Sources: Review of resident clinical records, review of the LTC Home's investigation notes, and an interview with staff.

A medication was not administered to the second resident in accordance with the directions for use specified by the prescriber. There were two missing entries in the Medication Administration Record (MAR) for the administration of this medication, on two separate dates, and no supportive documentation was found in the progress notes to indicate the administration of this medication. The staff confirmed the lack of documentation and acknowledged the medication was not provided to the resident.

Sources: Resident MAR, progress notes, and interviews with staff.

The second resident also required a medication to assist in disease management. In one month the resident did not receive this medication as order on multiple occasions. In an interview with staff they stated that the staff were to provide rationale for not giving the resident's medication and that the physician should have been called.

Sources: Interview with staff, medication administration record, and progress notes.

This order must be complied with by March 6, 2026

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.