

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: January 29, 2026

Inspection Number: 2026-1327-0001

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): January 20, 22, 23, 26, 27, 28, and 29, 2026.

The following intake(s) were inspected:

Intake: #00165143/CI #2842-000060-25 related to resident care and support services.

Intake: #00166594/CI #2842-000067-25 related to Influenza A outbreak.

Intake: #00165411- Complainant related resident care and support services.

Intake: #00167218 - Complainant related to medication management.

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

- Resident Care and Support Services
- Skin and Wound Prevention and Management
- Medication Management
- Infection Prevention and Control
- Reporting and Complaints
- Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident had an intervention in place for care. A staff member did not follow the intervention and acknowledged that they should have reviewed the resident's plan of care for direction, but they did not.

Sources: Resident's plan of care and kardex, as well as staff interviews.

WRITTEN NOTIFICATION: Skin and Wound Care

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Staff observed an area of impaired skin integrity on a resident. An initial assessment using the assessment tool in the resident's clinical chart was not completed.

Sources: Resident's progress notes, assessment tab in the clinical record, and staff interview.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

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(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated.

A resident had an area of impaired skin integrity that was changing in appearance. Some of the weekly reassessments completed by staff did not include all areas required in the assessment.

Sources: Resident's skin assessments and progress notes, as well as staff interview.

WRITTEN NOTIFICATION: Dealing With Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

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,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

A resident's family brought forward a complaint to the home. Staff who received the complaint stated that the Ministry of Long-Term Care's action line number was offered to the family but contact information for the patient ombudsman was not.

Sources: The home's complaint investigation form and interviews with staff.

WRITTEN NOTIFICATION: Missed Dose of Medication

NC #005 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. O. Reg. 246/22, s. 140 (2).

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A medication that was prescribed for a resident was not administered to the resident for five consecutive days.

Sources: Resident's progress notes and medication administration record, as well as staff interview.