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

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Original Public Report

Report Issue Date: May 30, 2024
Inspection Number: 2024-1388-0002
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Tecumseh, Tecumseh

Lead Inspector	**Inspector Digital Signature**
Adriana Tarte (000751)	Adriana Tarte Digitally signed by Adriana Tarte Date: 2024.06.11 09:08:28 -04'00'

Additional Inspector(s)
Debra Churcher (670)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 7-10, 13-16, 21, 23-24, 2024.

The following intakes were inspected:

- Intake #00112448 was related to an enteric outbreak
- Intake #00113218 was related to a complaint regarding outbreak management; and
- Intake #00113376 was related to an acute respiratory infection outbreak

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident received a weekly reassessment of their altered skin integrity.

Rationale and Summary
A resident had altered skin integrity with possible infection and treated with medications. A review of the relevant progress notes and a weekly impaired skin integrity assessment indicated that the altered skin integrity was documented as being present but no assessment was completed.

Review of the home's policy, Management of Skin Rashes, Lesions and Irritations Guidelines, stated in part, "Assessment of skin rashes, lesions, and irritations

(including location, size and characteristics). Any related pain or discomfort, treatment applied, identified cause (if known), communication, referrals (as applicable), and prevention strategies implemented. Assessment completed a minimum of every seven (7) days until resolved, including the need to continue treatment; any signs of improvement or worsening condition; dressing is dry and intact (if applicable); or if there are any signs of infection."

During an interview with the Director of Care (DOC), they indicated that the expectation would have been that weekly assessments would have been completed with all required information.

Not completing weekly wound assessments placed the resident at risk for potential undetected deterioration of the impaired skin integrity.

Sources: Resident records, the Home's policy and staff interview.

[725]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 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).

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

Rationale and Summary:
The resident was ordered an increase to one of their scheduled medication.

Review of the medication incident report which stated that the pharmacy had sent additional tablets of the medication. During the evening medication pass, the additional doses of medication for a period of three days were found to still be in the packaging and had not been given.

During an interview with the DOC, they acknowledged that the medications were not given to the resident as prescribed.

Failure to give medications as prescribed to the resident placed them at risk for a deterioration of their medical condition.

Sources: Resident clinical records and interview with DOC.

[670]