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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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: October 25, 2024

Inspection Number: 2024-1388-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Tecumseh, Tecumseh

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 16 - 18, 21 - 22, 2024

The following intakes were inspected:

- Intake: #00127179/Critical Incident (CI) #2904-000046-24 - alleged improper/incompetent treatment of a resident
- Intake: #00127774/CI#2904-000047-24 - alleged physical abuse to resident
- Intake: #00128884/CI#2904-000051-24 - alleged neglect to a resident
- Intake: #00128926 - complaint regarding alleged abuse/neglect to resident and other care concerns
- Intake: #00129082/CI#2904-000052-24 - injury of unknown cause

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

Continence Care
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident;

Introduction
The licensee failed to ensure that the resident's plan of care provided clear direction to staff.

Rational and Summary
A resident was identified in progress notes, and as per assessment, as requiring a specific transfer status. The care plan indicated a different transfer status. Staff indicated that the transfer status logo in the resident's room identified a different transfer status than the care plan.

By not ensuring clear direction was provided to the staff the resident was placed at risk from incorrect transfer.

Sources

Resident plan of care, physiotherapy referral, progress notes and staff interviews.

WRITTEN NOTIFICATION: Plan of care

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

Introduction
The licensee has failed to ensure that the fall prevention strategy identified in the care plan for a resident was implemented.

Rational and Summary
The resident's care plan included an intervention for falls prevention. Staff indicated the strategy was not in use at the time of resident's fall.

Not ensuring the intervention was in use placed the resident at an increased risk of falling.

Sources
Resident plan of care and staff interviews.