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

Original Public Report

Report Issue Date: July 26, 2023

Inspection Number: 2023-1055-0004

Inspection Type:
Follow up
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare London, London

Lead Inspector	**Inspector Digital Signature**
Tatiana Pyper (733564)	Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2023.07.26 14:38:56 -04'00'

Additional Inspector(s)
Christina Legouffe (730)
Christie Birch (740898)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 19, 20, 21, 24, and 25, 2023

The following intake(s) were inspected:

- Intake: #00084382 – CI# 2173-000008-23: related to care concerns.
- Intake: #00086748 - Follow-up # 005 - O. Reg. 246/22 - s. 153 (1).
- Intake: #00086749 - Follow-up # 001 - O. Reg. 246/22 - s. 74 (2) (a).
- Intake: #00086750 - Follow-up # 004 - O. Reg. 246/22 - s. 108 (1) 1. related to investigating a complaint.
- Intake: #00086751 - Follow-up # 002 - O. Reg. 246/22 - s. 102 (15) 2. related to IPAC Lead hours.
- Intake: #00086752 - Follow-up # 003 - O. Reg. 246/22 - s. 102 (2) (b).
- Intake: #00086753 - Follow-up # 006 - FLTCA, 2021 - s. 184 (3).
- Intake: #00087278 – CI# 2173-000014-23: related to Falls Prevention and Management.
- Intake: #00089419 – CI# 2173-000016-23: related to Prevention of Abuse and Neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #005 from Inspection #2023-1055-0003 related to O. Reg. 246/22, s. 153 (1) inspected by Christie Birch (740898)

Order #001 from Inspection #2023-1055-0003 related to O. Reg. 246/22, s. 74 (2) (a) inspected by Christina Legouffe (730)

Order #004 from Inspection #2023-1055-0003 related to O. Reg. 246/22, s. 108 (1) 1. inspected by Christie Birch (740898)

Order #002 from Inspection #2023-1055-0003 related to O. Reg. 246/22, s. 102 (15) 2. inspected by Christina Legouffe (730)

Order #003 from Inspection #2023-1055-0003 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Christina Legouffe (730)

Order #006 from Inspection #2023-1055-0003 related to FLTCA, 2021, s. 184 (3) inspected by Christina Legouffe (730)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CRITICAL INCIDENTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee has failed to ensure that the Director was informed of a significant change in health to a resident, within three business days after the occurrence of the incident.

Rationale and Summary

A Critical Incident System (CIS) Report was submitted to the Director.

A review of their clinical record and interviews with a Personal Support Worker (PSW), and a Registered Nurse (RN) indicated that the resident had a significant change in their health condition.

The Director of Care (DOC) acknowledged that the Director was not informed of the incident within three business days after the occurrence of the incident.

Sources: Review of clinical records for the resident and interviews with PSW, RN, and DOC.

[733564]