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

Central East District
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Oshawa, ON, L1H 1A1
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Public Report

Report Issue Date: May 9, 2025

Inspection Number: 2025-1071-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Oshawa, Oshawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-25, 28-30, 2025 and May 1-2, 5-9, 2025

The following intake(s) were inspected:

An intake to follow-up #1 - O. Reg. 246/22 - s. 102 (2) (b) CDD April 15, 2025
An intake related to a respiratory outbreak.
A complaint intake related to a Personal Health Information breach.
An intake resident had a choking episode.
An intake to follow-up #1 - FLTCA, 2021 - s. 6 (4) CDD April 4, 2025.
A complaint intake regarding denied admission.
An intake related to the improper care of a resident by staff.
Two intakes related to a fall incident of residents resulted in an injury.
Two intakes related to Emotional abuse of residents by staff.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2025-1071-0001 related to O. Reg. 246/22, s. 102 (2) (b)
Order #002 from Inspection #2025-1071-0003 related to FLTCA, 2021, s. 6 (4)

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The Director was made aware of an incident related to the disclosure of a resident's

health information.

A review of the home's internal investigation notes indicated that information related to the resident's health was not kept confidential. During an interview, the Director of Care (DOC) confirmed that health information related to the resident's health was shared.

Sources: Internal investigation notes, Critical Incident Report (CIR), and interview with DOC.

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.

The license failed to comply with a resident's plan of care that specified an aspect of care.

A CIR was submitted related to the fall of a resident. On review of the resident's care plan, there is an indication that after the incident, an intervention was implemented. During an interview with the Assistant Director of Care (ADOC), they confirmed that the staff were not following an aspect of the resident's plan of care related to the intervention.

Sources: A resident's clinical records, internal policies, CIR, and interview with the ADOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that a concern brought forward regarding alleged or suspected abuse of a resident was immediately investigated.

A registered nursing staff received a verbal report from a Personal Support Worker (PSW) related to a suspected emotional abuse of a resident. The registered staff reported the incident to the Social Worker and the ADOC, but the investigation did not initiate until ten days after the initial allegation of abuse was reported.

Sources: Home's internal investigation notes and interviews with the Registered Practical Nurse (RPN) and PSW.

WRITTEN NOTIFICATION: Reports of investigation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

A PSW reported an allegation of physical abuse of a resident by a staff member. The resident stated that during a transfer, the staff member was rough, which resulted in a skin injury. The home's investigation and CIR did not include the outcomes of the investigation or any actions taken as a result of the incident, which was confirmed by the ADOC.

Sources: CIR, home's internal investigation, interview with the ADOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 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.

1. The licensee failed to ensure that a verbal report made by a PSW, regarding an allegation of emotional abuse of a resident by another PSW, was reported immediately to the Director. As a result, the Director was not notified until ten days after the allegation was made.

Sources: CIR, home's internal investigation, interviews with the PSW, the RPN and the ADOC.

2. The licensee failed to ensure that a verbal report made by a PSW regarding an allegation of physical abuse of a resident by another staff member was reported immediately to the Director.

Sources: CIR, residents' clinical records, and interviews with the PSW and the ADOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The license failed to ensure that a resident was safely transferred.

The Director was made aware of a fall involving a resident. On review of the home's video surveillance footage of the fall, there is an indication that staff failed to safely transfer the resident after the fall had occurred. ADOC confirmed that the resident was to be transferred after the fall that occurred.

Sources: Internal policies, video surveillance footage, a resident's clinical records, interviews with the ADOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care

approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The license failed to ensure that a resident's fall prevention measures were in place.

The Director was informed of a fall involving a resident. On review of the home's internal investigation notes, there is an indication that the resident's fall prevention intervention was not functioning. After reviewing the video surveillance footage of the fall, there is an indication that the resident's fall prevention intervention was not in place.

RPN confirmed that at the time of the fall, there was no indication that the fall prevention intervention was in place. During an interview with the ADOC confirmed that the resident's fall prevention intervention alarm was not implemented.

Sources: Internal investigation notes, video surveillance footage, a resident's clinical records, interviews with RPN and ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O.

Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) when the resident exhibited an altered skin integrity. A review of the resident's clinical records and interviews with the RD and RPN confirmed that the registered staff did not complete a dietary referral to the RD related to the altered skin integrity on a specific date.

Sources: Resident's Clinical record, Long Term Care Home (LTCH)'s Policy for Dietary Referral, and interviews with RD and RPN.

WRITTEN NOTIFICATION: Weight Changes

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee failed to comply with the home's monitoring of resident weights policy when staff failed to immediately reweigh a resident when they had over a five percent weight loss over a specific period. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for their organized program of nutritional care and dietary services are complied with. Specifically, the home's monitoring of resident weights policy directs staff to immediately reweigh for accuracy if residents who have a specific weight difference from the previous month. The RD and RPN acknowledged that this should have been done.

Sources: LTCH's Policy for Height and Weight Monitoring, Resident's Clinical records, and interviews with RD and RPN.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that a CIR submitted to the Director included the names of the alleged staff involved in the allegation of abuse towards a resident.

Sources: CIR and interview with the ADOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out

the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to ensure the CIR included the immediate actions taken regarding the staff involved in the allegation of abuse towards a resident. Additionally, the long-term measures intended to address the issue and prevent its recurrence were not described.

Sources: CIR and interview with the ADOC.

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