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: May 17, 2024	
Inspection Number: 2024-1175-0002	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Port Stanley, Port Stanley	
Lead Inspector Loma Puckerin (705241)	**Inspector Digital Signature** Loma Puckerin Digitally signed by Loma Puckerin Date: 2024.05.17 15:23:06 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00109257 related to a disease outbreak.
- Intake: #00111195 related to the fall of a resident.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re critical incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director is immediately informed of a disease outbreak that occurred within the home.

Rationale and Summary
A critical incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC). The CI indicated the home was in an outbreak.

The home's Director of Care (DOC) and the Infection prevention and control (IPAC) lead both acknowledged during interviews that the (CI) report was submitted late to the Ministry of Long-Term Care (MLTC).

A review of the CI showed that the outbreak occurred on a specific date, and the

report was not submitted immediately as required by the Fixing Long-term Care Act.

There was a minimal risk to residents' safety due to the late reporting of the CI.

Sources: Interviews with DOC and IPAC lead; and CI report.

[705241]

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