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

Public Report

Report Issue Date: February 6, 2025

Inspection Number: 2025-1175-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Port Stanley, Port Stanley

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 28, 29, 30, 31, 2025 and February 3, 4, 5, 6, 2025
The inspection occurred offsite on the following date(s): February 3, 2025
The following intake(s) were inspected:

- Intake: #00137302 - Proactive Compliance Inspection (PCI)

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the long-term care home's policy to promote zero tolerate of abuse and neglect of residents was posted in the home, as observed on the initial tour of the home. The Director of Care (DOC) was informed and a copy of the home's policy was available at the information board later on in the day.

Sources: Observations of the home's information board, interview with the DOC.

Date Remedy Implemented: January 28, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that the doors to the supply room and the electrical and mechanical room were locked during the initial tour of the home.

On January 29, 2025, maintenance staff repaired the locking mechanism on the supply room door to ensure the door locked when closed and the electrical and mechanical room door was locked.

Sources: Initial tour of the home, and interviews with the Administrator and other staff.

Date Remedy Implemented: January 29, 2025

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee has failed to ensure that every window in the home that opened to the outdoors and were accessible to residents could not be opened more than 15 centimetres.

Awning windows in three resident rooms that opened to the outside were measured to open 20 centimetres.

On February 4, 2024, Maintenance Staff (MS) #121 showed inspectors that they had placed screws in the windows to limit the windows from opening more than 15 centimetres.

Sources: Measurements of windows in three resident rooms; and interview with MS #121 and the Administrator.

Date Remedy Implemented: February 4, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #004 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 licensee has failed to ensure that a resident's plan of care related to nutrition care was complied with. During lunch service, a resident was served a portion size that was not their preferred portion size.

Sources: Observations of lunch service, clinical records for a resident, and an interview with Dietary Aide #110.

WRITTEN NOTIFICATION: Accommodation Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home was maintained in a good state of repair.

During an initial tour of the home, the bathroom doors and walls in two resident rooms were noted to be in a state of disrepair with gouges, peeling paint and loose trim.

Sources: Observation of resident rooms and interviews with Maintenance Staff #121 and the Administrator.

WRITTEN NOTIFICATION: General Requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who

participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

A) The licensee has failed to ensure that a written record of the home's 2024 pain management program evaluation included the date of the evaluation, or a summary of changes made and the date those changes were implemented.

Sources: Review of the home's program records and interview with the Director of Care and Administrator.

B) The licensee has failed to ensure that a written record was kept of the annual evaluation for the home's skin and wound care program. The home was unable to provide inspectors with a copy of a written record for the 2024 evaluation of the home's skin and wound care program.

Sources: Interviews with the Administrator and other staff.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (2)
Nursing and personal support services
s. 35 (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

The licensee has failed to ensure that there was a written staffing plan for the organized program of nursing services and the organized program of personal support services.

Sources: Interview with the Director of Care and the Scheduling and Attendance

Coordinator and review of the home's staffing contingency plan.

WRITTEN NOTIFICATION: Nursing and Personal Support Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure that a written record of the home's 2024 staffing plan evaluation included the date of the evaluation, or a summary of changes made and the date those changes were implemented.

Sources: Interview with the Director of Care and the Scheduling and Attendance Coordinator, and review of the home's staffing evaluation.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 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 an authorized person described in subsection

(2.1), if clinically indicated;

The licensee has failed to ensure that two residents who exhibited altered skin integrity, were reassessed at least weekly, if clinically indicated.

a) A resident had several areas of altered skin integrity. Weekly reassessments of the areas were not fully completed, as per the expectation of the home. A weekly reassessment of one of the areas of altered skin integrity was not completed, as scheduled.

b) A resident had an area of altered skin integrity. Weekly reassessments of the area were not fully completed on four occasions, as per the expectation of the home.

Sources: Clinical records for two residents including assessments and Treatment Administration Record, and interviews with Resident Assessment Instrument Coordinator #111 and other staff.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to comply with the home's nutritional care and dietary

services and hydration policy related to food temperature monitoring on a specific date.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and procedures were developed for the nutritional care and dietary services and hydration program and ensure that they were complied with. Specifically, staff did not comply with the licensee's "Temperatures of Food at Point of Service," policy (last reviewed January 2022), which stated that staff were to monitor and record food temperatures on the Food Temperature Record.

On a specific date, food temperatures were not measured or documented for certain items for two meals.

Sources: Temperatures Records, the home's policy titled "Temperatures of Food at Point of Service" (Reviewed January 2022), and an interview with Dietary Aide #110.

WRITTEN NOTIFICATION: Food Production

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)
Food production
s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that a menu substitution for the soup choice was communicated to residents during a meal service. This substitution was not noted on the menu board or verbally communicated to residents as per the home's process.

Sources: Observation of meal service, record review of the home's menu, and interviews with Dietary Manager #103 and other staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The licensee has failed to ensure that a resident was provided with the eating aids, personal assistance, and encouragement required to safely eat and drink as comfortably and independently as possible.

Sources: Observation of a meal service, clinical records for a resident and interview with Registered Dietitian #116 and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection

prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (revised September 2023), the licensee has failed to ensure that Routine Practices were followed in the IPAC program, specifically related to the completion of hand hygiene by a registered nurse.

Sources: Observations of a medication pass and interviews with Registered Nurse #126 and the Director of Care.

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that a quarterly evaluation of the home's medication management system was completed for October 2024.

Sources: Review of the home's medication management system records and an

interview with the Director of Care.

WRITTEN NOTIFICATION: Annual Evaluation

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that an annual evaluation of the home's medication management system was completed in 2024.

Sources: Review of the home's medication management system records and an interview with the Director of Care.

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are

none, in accordance with prevailing practices.

The licensee has failed to ensure that non-narcotic and non-controlled drugs were destroyed when the Director of Care (DOC) and Pharmacist #125 completed drug destruction in the home.

Inspectors observed that non-narcotic and non-controlled drugs were left in their original packaging as part of the drug destruction process, therefore the drugs were not altered or denatured to such an extent that its consumption was rendered impossible or improbable.

Sources: Observation of drug destruction in the home; review of MediSystem Drug Destruction policy dated August 2024; and interviews with Registered Nurse #119, Pharmacist #125 and the DOC.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must:

1.Ensure that all staff who complete lifts and transfers for residents, receive in-person and hands-on retraining on the home's safe lift and transfer program. Maintain a written record of the education provided, the staff members who

completed the education, the date(s) and time(s) the education occurred and the name(s) of the person(s) who provided the education.

2.Develop and implement weekly audits of, at a minimum, three residents who require total assistance with transfers to ensure safe lift and transfer techniques are being used. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

Grounds

The licensee has failed to ensure that staff used safe transferring techniques with a resident.

Observation of a resident noted that staff did not use safe lift and transfer techniques.

The resident's care plan gave specific instructions related to lifts and transfer.

Personal Support Worker (PSW) #112 and #114 both stated it was common practice to do this with four specific residents.

The Director of Care (DOC) stated safe lift and transferring techniques were not used with the resident. The resident was at increased risk for injury when staff did not use safe lift and transferring techniques.

Sources: Observations of a resident; review of the resident's care plan, the home's "Safe Lifting With Care Program" RC-08-01-11 A2 last reviewed November 2023, ARJO Maxi Move Instructions for Use; and interviews with PSW #112, PSW #114, Resident Assessment Instrument (RAI) Coordinator #111, the DOC and the Administrator.

This order must be complied with by March 10, 2025

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor

Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.