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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Original Public Report

Report Issue Date: May 30, 2024	
Inspection Number: 2024-1388-0003	
Inspection Type: Complaint	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Tecumseh, Tecumseh	
Lead Inspector Adriana Tarte (000751)	**Inspector Digital Signature**
Additional Inspector(s) Debra Churcher (670)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 13-14, 21, 23-24, 2024.

The following intakes were inspected:

- Intake #00115160 and Intake #00115271 were related to complaints regarding skin and wound prevention and management and medication management.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 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 a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident was reassessed at least weekly when they were exhibiting altered skin integrity.

Rationale and Summary
A review of a head to toe skin assessment completed by the skin and wound nurse showed that the resident had three areas of compromised skin integrity. The assessment indicated the need for weekly assessments for these skin and wound concerns. The home initiated weekly skin and wound assessments for only one of the three skin and wound concerns.

The home's skin and wound policy directed registered nursing staff to re-assess at least weekly, if clinically indicated, any resident exhibiting any form of altered skin integrity. Per the policy, any form of altered skin integrity included skin breakdown, unexplained bruises, pressure injuries, skin tears and wounds.

During an interview with the Director of Care (DOC) and the Assistant Director of

Care (ADOC), they confirmed the skin and wound concerns should have been assessed weekly.

When the home did not complete weekly assessments of the resident's impaired skin integrity, the risk of complications related to the impaired skin integrity may not have been identified and treatment may not have been initiated immediately.

Sources: Resident skin and wound assessments; skin and wound program; and interview with staff.

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WRITTEN NOTIFICATION: Substitute decision-maker Notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)
Reports re critical incidents
s. 115 (6) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was promptly notified of a serious illness of the resident.

Rational and Summary
A review of the progress notes showed that the resident was assessed for signs and symptoms of a serious illness requiring hospitalization. A progress note from a

registered staff member indicated that there was a delay in notifying the SDM.

The registered staff acknowledged that they did not know they had to contact the SDM. They stated that the SDM was not notified until three hours after the incident. They acknowledged that they felt it was not an emergency, but they suspected a serious illness. An interview with the DOC and the ADOC confirmed that there was a delay in notifying the SDM and education was provided to the registered staff.

A review of the Notification of Family/Substitute Decision-Maker policy stated that each home will follow all applicable local, provincial, and federal legislative requirements in order to notify the SDM, power of attorney (POA), or any other persons identified of importance to the resident that there has been a change in the resident's medical health.

Sources: Resident health records, Notification of Family/Substitute Decision-Maker policy, and interviews with staff.

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