Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 8, 2022
Inspection Number 2022_1409_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare, Port Hope

Lead Inspector
Karyn Wood (601)

Additional Inspector(s)
Julie Dunn (706026)

Karyn L Wood

Choose an item.
Digitally signed by Karyn L Wood
Date: 2022.07.19 10:07:13 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 10, 11, 12, and 13, 2022.

The following intake was completed in this complaint inspection:

Log was related to the long-term care home's complaint process, falls prevention measures, concerns with family council, bathing, and Infection Prevention and Control (IPAC).

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Reporting and Complaints
- Resident Care and Support Services
- Residents' and Family Councils

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

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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)

FLTCA, s. 6. (7)

The licensee has failed to ensure that the care set out for in the plan of care for bathing was provided to the resident, as specified in the plan.

Rationale and Summary
The Ministry of Long-Term care received a complaint that resident #001 would go several days without a bath or shower.

Record review and staff interviews identified the resident would often refuse their scheduled shower. The resident's documented plan of care and preference for bathing was to receive a shower twice a week. A PSW reported the resident was bathed in the bathtub and was not provided a shower.

The Director of Care (DOC) indicated they were not aware the resident's preference to shower for bathing was not followed, as specified in the resident's plan of care. The DOC developed and implemented a plan to ensure the resident was offered a shower on their scheduled bath day.

There was no impact and low risk to the resident when they did not receive their shower.

Date Remedy Implemented: May 12, 2022 [601]