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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: 2023-09-22	
Inspection Number: 2023-1343-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Hamilton, Hamilton	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s) Indiana Dixon (000767)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 10, 11, 14, 15, 16, 2023

The following intake(s) were inspected:

- Intake: #00002721 - [CI: 2858-000002-22] – Related to Prevention of Abuse and Neglect
- Intake: #00091857 - [CI: 2858-000011-23] - Related to Falls Prevention and Management.
- Intake: #00092186 - Complaint related to Resident’s Plan of Care and Falls Prevention and Management.
- Intake: #00092623 - [CI: 2858-000012-23] - Related to Falls Prevention and Management.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

A resident's Plan of care stated that the resident required 1:1 constant monitoring and staff were to ensure that there was always a staff-relieve present prior to taking breaks and that the resident should not be left unattended. The resident had a fall and 1:1 staff was not present at the time resident had the fall.

The Assistant Director of Care (ADOC) confirmed that the resident required 1:1 monitoring and should not have been left alone.

The home not ensuring that 1:1 constant monitoring was provided to a resident, resulted in resident having a fall.

Sources: Progress note, Plan of care, interview with ADOC, Falls Lead and RN.
[741771]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect a resident from abuse.

A resident pushed another resident, and the fall resulted in the resident sustaining an injury. Although the event was witnessed by staff, the staff was not able to intervene in time.

During an interview, a staff member acknowledged that a resident pushed co resident and as a result, the resident sustained an injury.

The ADOC acknowledged that the home did not protect the resident from abuse, which resulted in the resident sustaining an injury.

Sources: Critical Incident, interview with ADOC, SW and Staff
[741771]

WRITTEN NOTIFICATION: Foot Care and Nails

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (1)

The licensee has failed to ensure that a resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

An observation of a resident’s feet indicated that the resident’s toenails have not been cut for at least two weeks. The resident’s care plan states that the resident’s nails should be cut weekly. Following the observation, inspector followed up days later and there was no documentation to show that the resident’s nails had been cut after inspector’s initial observation. The home’s plan of care for the resident was not followed when resident did not receive foot care as per the plan of care.

On August 10, 2023, one staff observed a resident’s foot and acknowledged that staff did not provide the resident with foot care for at least two weeks.

The home not ensuring that footcare is provided weekly to a resident, could have put the resident at a health risk.

Sources: Observation, Plan of care, interview with ADOC and RN.
[741771]