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

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

# Original Public Report

| |
|---|
| **Report Issue Date:** May 30, 2024 |
| **Inspection Number:** 2024-1343-0003 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** Extendicare (Canada) Inc. |
| **Long Term Care Home and City:** Extendicare Hamilton, Hamilton |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Dusty Stevenson (740739) | Dusty Stevenson<br>Digitally signed by Dusty Stevenson<br>Date: 2024.06.03 12:18:32 04'00' |

**Additional Inspector(s)**
Sarah Valente (000847)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24, 27-28 2024
The inspection occurred offsite on the following date: May 29, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00114357/CI#2858-000009-24 was related to prevention of abuse and neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 25 (1)**
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to follow their policy on abuse and neglect as they did not immediately assess a resident after becoming aware of an allegation of abuse

**Rationale and Summary**
Staff were made aware of an allegation of abuse by a resident, but documented that an assessment was completed three days later. As per the homes abuse and neglect policy complete assessments are to be done by staff after an allegation of abuse. During an interview with a staff member it was confirmed that an assessment should be completed immediately after staff are made aware of an allegation of abuse.

Not conducting complete assessments immediately after an allegation of abuse could have impacted the investigation of the abuse and put the resident at risk of

further harm.

**Sources:** Record review of the homes abuse and neglect policy; record review of investigation notes; interview with staff. [000847]

## WRITTEN NOTIFICATION: Police notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 105**
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure police services were notified immediately after an allegation of abuse was made by a resident.

**Rationale and Summary**
Staff were made aware of an allegation of abuse made by a resident. Staff did not notify police services immediately as indicated in the homes policy on abuse and neglect. A staff member confirmed during an interview that police should have been notified when they were made aware of the incident.

Failing to notify police services may have impacted the investigation into the alleged abuse.

**Sources:** Review of homes policy on abuse and neglect, CIS report, Interview with staff. [000847]