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: April 11, 2024	
Inspection Number: 2024-1343-0002	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Hamilton, Hamilton	
Lead Inspector Parminder Ghuman (706988)	**Inspector Digital Signature** Parminder Ghuman Digitally signed by Parminder Ghuman Date: 2024.04.29 09:28:37 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2-4 & 9, 2024.

The following intake(s) were inspected:

- Intake: #00111664 - Critical Incident (CI) #2858-000007-24 - Fall of resident resulting in fractured hip.

The following intake(s) were completed:

- Intake: #00101402 – CI #2858-000015-23 - Fall of resident resulting in head injury.
- Intake: #00110046 - 2858-000004-24 - Fall of resident resulting in femur fracture.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. 0. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their strategy related to falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

Rationale and Summary
In accordance with 0. Reg 246/22, s.11 (1) (b) the licensee was required to ensure to implement Universal Falls Precautions for all residents, that the policy was complied with.

Specifically, staff did not comply with safe environment by having brakes on the bed. The policy directed to implement SAFE Universal Falls Precautions for all

residents by providing safe environment with bedrails removed/down based on assessed need, clutter- free, brakes on and light on must be complied with.

During the audio recorded interviews with Registered Staff, they acknowledged that staff did not comply with the Policy for falls prevention and management program of the home as brakes of the bed were not on and the resident fell which could have been prevented if all the interventions were followed. DOC also confirmed during audio recorded interview that Falls Prevention and Management Policy was not followed.

There was an increased risk for not following the policy as this lead to significant change in the resident's health condition.

Sources: Resident's progress notes, Falls Prevention and Management Program RC 15-01-01, Last Reviewed March 2023 and interviews with staff and DOC.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The Licensee has failed to that the Director is informed of the incidents in the home no later than one business day after the occurrence of the incident, Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Rationale and Summary

Critical Incident (CI) was reported on March 18, 2024, and the incident occurred on March 13, 2024. The home was aware of the significant change that required surgical intervention on March 14, 2024 but CIS was not submitted till March 18, 2024. The Director of Care (DOC) acknowledged that this injury had a significant impact on the resident and CIS was reported late.

Resident was transferred to hospital on March 13, 2024, after a fall. Hospital had confirmed the injury which required surgical intervention on March 14, 2024, which was documented in progress notes by Registered Staff. During the audio recorded interview with DOC, they acknowledged that they were not aware of the confirmation of the injury from the hospital, and no one has communicated this to the DOC. This was late reporting as per DOC.

Not reporting certain matters to the Director no later than one business day after the occurrence of the incident puts the residents at risk of harm for the resident.

Sources: CI Report, resident's progress notes and interviews with Staff and DOC.

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