

Inspection Report under  
the Long-Term Care  
Homes Act, 2007

Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée

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

Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée

Hamilton Service Area Office  
119 King Street West 11th Floor  
HAMILTON ON L8P 4Y7  
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Bureau régional de services de  
Hamilton  
119, rue King Ouest 11<sup>ième</sup> étage  
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**Public Copy/Copie du rapport public**

| Report Date(s) /<br>Date(s) du Rapport | Inspection No /<br>No de l'inspection | Log # /<br>No de registre                                                                                           | Type of Inspection /<br>Genre d'inspection |
|----------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Nov 5, 2021                            | 2021_820130_0010                      | 022018-20, 002404-<br>21, 003556-21,<br>006559-21, 007164-<br>21, 012774-21,<br>012840-21, 014034-<br>21, 014749-21 | Critical Incident<br>System                |

**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

**Long-Term Care Home/Foyer de soins de longue durée**

Extendicare St. Catharines  
283 Pelham Road St Catharines ON L2S 1X7

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

GILLIAN HUNTER (130), AILEEN GRABA (682), CATHY FEDIASH (214)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 4, 5, 6, 7, 8, 12, 13, 14, 2021.**

**The following intakes were completed during this critical incident system inspection:**

**Log #022018-20, #006559-21, #007164-21 and #007164-21 related to falls;  
Log #002404-21 related to abuse;  
Log #003556-21 related to reporting matters to the Director;  
Log #012774-21 and #014749-21 related to injury unknown origin; and  
Log #012840-21 related to improper care.**

**During this inspection the home was toured, the provision of care was observed, and records including clinical records, policies and procedures, critical incident and complaint investigation files were reviewed**

**Please note: this inspection was conducted concurrently with the following Complaint Inspection (2021\_820130\_0009).**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Wound Care Nurse, Resident Assessment Instrument (RAI) Coordinator, registered staff, personal support workers, housekeepers and residents.**

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

**Falls Prevention  
Infection Prevention and Control  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation**

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During the course of this inspection, Non-Compliances were issued.

1 WN(s)  
0 VPC(s)  
1 CO(s)  
0 DR(s)  
0 WAO(s)

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Legend</p> <p>WN – Written Notification<br/>VPC – Voluntary Plan of Correction<br/>DR – Director Referral<br/>CO – Compliance Order<br/>WAO – Work and Activity Order</p>                                                                                                                                                                                                                          | <p>Légende</p> <p>WN – Avis écrit<br/>VPC – Plan de redressement volontaire<br/>DR – Aiguillage au directeur<br/>CO – Ordre de conformité<br/>WAO – Ordres : travaux et activités</p>                                                                                                                                                                                                                                        |
| <p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

The licensee failed to ensure that staff use safe positioning techniques when assisting a resident.

According to written records a staff member provided care to a resident while in bed, without the assistance of another staff member. During the provision of care the resident was positioned, without a second staff member present, and an incident occurred where they sustained an injury. The resident's plan of care indicated that they required assistance by two staff with bed mobility.

Staff who completed the assessment following the incident acknowledged that at the time there was only one staff who was providing care.

The staff member who provided the care at the time of the incident confirmed that, they were alone, getting supplies ready when they had taken their hand away from the resident and that they had not safely positioned the resident.

The resident sustained an injury when staff did not safely position them and failed to provide care as directed in the plan of care.

Sources: A resident's electronic medical record (EMR), the home's investigation notes, interviews with staff. [s. 36.]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 6th day of December, 2021**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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

Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** GILLIAN HUNTER (130), AILEEN GRABA (682),  
CATHY FEDIASH (214)

**Inspection No. /**

**No de l'inspection :** 2021\_820130\_0010

**Log No. /**

**No de registre :** 022018-20, 002404-21, 003556-21, 006559-21, 007164-  
21, 012774-21, 012840-21, 014034-21, 014749-21

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Nov 5, 2021

**Licensee /**

**Titulaire de permis :** Extendicare (Canada) Inc.  
3000 Steeles Avenue East, Suite 103, Markham, ON,  
L3R-4T9

**LTC Home /**

**Foyer de SLD :** Extendicare St. Catharines  
283 Pelham Road, St Catherines, ON, L2S-1X7

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Jane Freeman

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**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following  
order(s) by the date(s) set out below:

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**Order # /**

**No d'ordre :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee must comply with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that residents who are at risk of falls are provided care in a safe position in bed.
  - a) Perform weekly audits to ensure residents at risk for falls are safely positioned in bed while an identified staff member is providing care.
  - b) Document the weekly audits and continue auditing until no further concerns arise with the staff member safely positioning residents in bed during the provision of care.

**Grounds / Motifs :**



**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

1. The licensee failed to ensure that staff use safe positioning techniques when assisting a resident.

According to written records a staff member provided care to a resident while in bed, without the assistance of another staff member. During the provision of care the resident was positioned, without a second staff member present, and an incident occurred where they sustained an injury. The resident's plan of care indicated that they required assistance by two staff with bed mobility.

Staff who completed the assessment following the incident acknowledged that at the time there was only one staff who was providing care.

The staff member who provided the care at the time of the incident confirmed that, they were alone, getting supplies ready when they had taken their hand away from the resident and that they had not safely positioned the resident.

The resident sustained an injury when staff did not safely position them and failed to provide care as directed in the plan of care.

Sources: A resident's electronic medical record (EMR), the home's investigation notes, interviews with staff. [s. 36.]

An order was made by taking the following factors into account:

Severity: A staff member provided care to the resident in an unsafe position and sustained injuries.

Scope: This was an isolated case as no other incidents of unsafe positioning were identified during this inspection.

Compliance History: In the last 36 months, five other (compliance orders) CO were issued to different sections of the legislation, which have been complied.  
(682)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

Dec 31, 2021

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

**TAKE NOTICE:**

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8th Floor  
Toronto, ON M7A 1N3  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8th Floor  
Toronto, ON M7A 1N3  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
438, rue University, 8e étage  
Toronto ON M7A 1N3  
Télécopieur : 416-327-7603

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
438, rue University, 8e étage  
Toronto ON M7A 1N3  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5th day of November, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Gillian Hunter

**Service Area Office /**

**Bureau régional de services :** Hamilton Service Area Office