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: October 18, 2023	
Inspection Number: 2023-1064-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare St. Catharines, St Catharines	
Lead Inspector Emma Volpatti (740883)	**Inspector Digital Signature** Emma Volpatti Digitally signed by Emma Volpatti Date: 2023.11.08 12:58:53 -05'00'
Additional Inspector(s) Brittany Wood (000763)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27-29, 2023 and October 3-6, 2023

The following intake(s) were inspected:

- Intake: #00022016 (Critical Incident (CI)# 2321-000015-23) related to the prevention of abuse and neglect.
- Intake: #00087246 (CI# 2321-000027-23) related to the prevention of abuse and neglect.
- Intake: #00087261 (CI# 2321-000028-23) related to the prevention of abuse and neglect.
- Intake: #00091891 Complaint related to falls prevention and management, care and services, plan of care and medication management.
- Intake: #00093570 (CI# 2321-000047-23) related to resident care and services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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 (1) (c)

A) The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff.

Rationale and Summary
A resident had special instructions written for medications to be administered a certain way. A review of their electronic medication administration record (EMAR) indicated that three of the residents' daily medications had different instructions for administration.

The Director of Care (DOC) acknowledged that this provided unclear direction to staff regarding medication administration for the resident.

Sources: A resident's clinical record, interview with the DOC and other staff. **[740883]**

B) The licensee has failed to ensure that the written plan of care for a resident provided clear directions to staff.

Rationale and Summary
FLTCA, 2021 s. 36 (2) defines a PASD as being a device used to assist a person with a routine activity of living.

A resident's plan of care indicated they required a certain device as a PASD. Progress notes indicated the

Substitute Decision Maker (SDM) consented to the use of the PASD. A review of the consent form signed by the SDM indicated the consent was for the device to be used as a restraint.

The DOC acknowledged that the wrong consent form was used, which provided unclear direction to staff on whether the device was to be used as a PASD or as a restraint.

By failing to ensure that the plan of care for the resident provided clear direction to staff, it posed a risk of injury to the resident.

Sources: A resident's clinical record, interview with the DOC and other staff. **[740883]**

WRITTEN NOTIFICATION: Complaints Procedure - Licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to forward a written complaint regarding the operation of the home immediately to the Director.

Rationale and Summary
A written complaint was sent to the Support Services Manager (SSM) alleging abuse. The written complaint was never forwarded to the Director.

The Administrator acknowledged that the complaint was not forwarded, and it should have been.

Sources: Ministry of Long-Term Care (MLTC) reporting system, written complaint, interview with the Administrator. **[740883]**

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report abuse of a resident by anyone that resulted in risk of harm to two residents.

Rationale and Summary
An altercation between two residents resulted in an injury to both residents. The residents were separated, and changes were made to both of their plans of care. There were no further incidents between the residents.

A CI was not immediately reported to the MLTC after the incident had occurred. The Administrator

acknowledged the incident was not reported immediately and it should have been.

Failure to report certain matters to the Director immediately had potential to put the residents at further risk of harm or abuse.

Sources: CI report, Interview with the Administrator. **[000763]**

WRITTEN NOTIFICATION: Protection From Certain Restraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 3.

The licensee has failed to ensure that a resident was not restrained by the use of a physical device.

Rationale and Summary
A resident was assessed for the use of a specific device as a PASD by a Registered Nurse (RN). The assessment indicated that the device would be used for a specific purpose.

The resident's progress notes indicated there were three occasions where the staff used the device for a different purpose.

The DOC acknowledged that this was not the proper use for the PASD as defined in the assessment, and the resident was restrained on those occasions.

Failing to ensure that the resident was not restrained by the use of a physical device posed a risk of injury to the resident.

Sources: A resident's clinical record, interview with the DOC and other staff. **[740883]**

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
A resident sustained a fall from their bed. A Personal Support Worker (PSW) attended to the resident and transferred them back into their bed without an assessment by a member of the Registered Nursing staff.

The home's policy indicated that when a resident falls, a member of the Registered Nursing staff must

assess the resident before they are transferred.

The Administrator acknowledged that the resident was not assessed prior to being transferred back to bed, leading to an unsafe transfer by the PSW.

By failing to transfer a resident safely, it posed a risk of the resident sustaining an injury.

Sources: CI report, interview with a PSW and other staff, the home's policy, home's investigation notes. **[740883]**

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee has failed to ensure that when a resident fell, they were assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary
A resident sustained a fall. A review of their clinical record indicated there was no post-fall assessment conducted using a clinically appropriate assessment instrument specifically designed for falls.

The DOC acknowledged that the resident was not assessed and no post-fall assessment was completed and that it should have been.

By failing to complete a post-fall assessment it posed a risk to the resident of potential injuries going undetected.

Sources: A resident's clinical record, CI report, interview with a PSW and other staff, the home's policy, home's investigation notes. **[740883]**

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)

The licensee has failed to ensure that for each resident with responsive behaviours the behavioural triggers were identified, where possible.

Rationale and Summary
A resident had responsive behaviours. Their plan of care did not identify any triggers for the resident's

responsive behaviours. An RN and the Administrator both confirmed the resident did not have behavioural triggers in their care plan and that they should have.

Additionally, the home's responsive behaviours policy indicated to ensure that the plan of care included triggers to the behaviour.

Failure to ensure that the resident's behavioural triggers were identified in their plan of care led to risk of harm to residents and others.

Sources: The home's policy, a resident's clinical records, interview with an RN and Administrator.
[000763]

COMPLIANCE ORDER CO #001 Duty of Licensee to Comply with Plan

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Provide education for all Registered Nursing staff who work regularly on an identified floor on the importance of implementing physician's orders when they are received; and
2. Document the education, including the date it was held, the staff members who attended and the staff's signatures that they understood the education; and
3. The home must keep a record of this education for the LTCH Inspector to review.

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

Rationale and Summary
A resident's SDM discussed concerns surrounding a specific intervention for the resident with the Physician (MD). The MD wrote an order for the intervention to not be applied during a specific timeframe, and to use a different intervention instead.

The resident's progress notes indicated on seven occasions after the order was written, the intervention was applied during that timeframe, instead of the different intervention the MD ordered.

The DOC acknowledged that the MD's order was part of the plan of care, and that staff were not following the order as specified.

Failing to ensure that the care set out in the resident's plan of care was provided as specified in the plan posed a risk of injury to the resident.

Sources: A resident's clinical record, interview with the DOC and other staff. **[740883]**

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

Rationale and Summary
A resident's plan of care indicated for staff to use a specific technique when the resident was resisting care. On a specific date, the resident was resisting care and was being physically aggressive towards staff. A PSW did not use the specific technique and continued to provide care.

The Administrator acknowledged that the PSW did not follow the plan of care that was set out for the resident.

Failure to ensure that the care set out in the plan of care for the resident led to an increased risk to the resident's safety.

Sources: A resident's clinical records, the home's investigation report, interview with the Administrator. **[000763]**

This order must be complied with by: November 16, 2023

COMPLIANCE ORDER CO #002 Duty to Protect

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Provide education for all Registered Nursing staff and Personal Support Workers on a specific floor on:
- A resident's responsive behaviours; and
- The importance of ensuring triggers are outlined in the plan of care for residents who exhibit aggressive responsive behaviours; and
- The home's policy on prevention of abuse and neglect; and
2. Document the education, including the date it was held, the staff members who attended and the staff's signatures that they understood the education; and
3. The home must keep a record of this education for the LTCH Inspector to review.

Grounds
A) The licensee has failed to protect a resident from verbal abuse.

Rationale and Summary
Section 2 of the Ontario Regulation (O. Reg) 246/22 defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

A PSW was yelling and made inappropriate comments towards a resident which resulted in the resident being in emotional distress.

An interview with another PSW confirmed the PSW was yelling and made inappropriate comments to the resident.

The Administrator confirmed that verbal abuse occurred from the PSW towards the resident.

Failure to protect the resident, led to harm to the resident's sense of well-being, dignity or self-worth.

Sources: The home's investigation notes, interview with a PSW and the Administrator. **[000763]**

B) The licensee has failed to protect residents #003 and #004 from physical abuse.

Rationale and Summary
Section 2 of Ontario Regulation (O. Reg) 246/22 defines "physical abuse" as the use of physical force that causes physical injury to another resident.

Two residents had an altercation which resulted in both residents receiving physical injuries.

The Administrator acknowledged physical injury occurred to each resident.

Failure to protect both residents from physical abuse led to actual harm to both residents.

Sources: Residents clinical records, interview with Administrator. **[000763]**

This order must be complied with by: November 29, 2023

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.