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
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: December 19, 2023	
Inspection Number: 2023-1064-0005	
Inspection Type: Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare St. Catharines, St Catharines	
Lead Inspector Indiana Dixon (000767)	**Inspector Digital Signature** Indiana A Dixon Digitally signed by Indiana A Dixon Date: 2023.12.20 08:32:25 -05'00'
Additional Inspector(s) Emily Robins (741074)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 7, 8, 11, 12, 2023

The following intake(s) were inspected:

- Intake: #00102735 - [Critical Incident (CI): 2321-000065-23] related to Falls Prevention Management.
- Intake: #00102750 - [CI: 2321-000066-23] related to Falls Prevention Management/Pain Management.
- Intake: #00099757 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1) Duty to Protect. Issued under inspection # 2023-1064-0004. Compliance Due Date (CDD) November 29, 2023.

- Intake: #00099756 - Follow-up #: 2 - FLTCA, 2021 - s. 6 (7) Duty of Licensee to Comply with Plan. Issued under inspection #2023-1064-0004. Compliance Due Date (CDD) November 16, 2023.

The following intakes (s) were completed in this inspection:
Intake: #00089396, CI: 2321-000035-23; Intake: #00090969, CI: 2321-000038-23; Intake: #00091710, CI: 2321-000041-23; Intake: #00095126, CI: 2321-000050-23 were related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1064-0004 related to FLTCA, 2021, s. 6 (7) inspected by Emily Robins (741074)

Order #002 from Inspection #2023-1064-0004 related to FLTCA, 2021, s. 24 (1) inspected by Indiana Dixon (000767)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
Falls Prevention and 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 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary

A resident had a diagnosis of a health condition. An order stated the resident to have their international normalized ratio (INR) checked monthly. The resident INR was not checked on a specified date.

When the resident's INR was checked at a later date, the INR result was greater than ten.

Failure to carry out a resident's order as required put them at risk of complications.

Sources: A resident's orders, lab work, progress notes, and interview with a member of the management team.

[741074].

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

Plan of care

When reassessment, revision is required

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(c) care set out in the plan has not been effective.

The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective.

A) Rationale and Summary

A referral was completed for physiotherapy. A member of the rehabilitation staffing team assessed the resident on the same day and prescribed treatment.

A staff member indicated that they were aware that the prescribed intervention was not effective, and that they did not follow up with the resident as they had intended to.

Sources: A resident's progress notes, physiotherapy referrals, and interview with a member of the rehabilitation staffing team.

[741074].

B) Rationale and Summary

A resident had a diagnosis of a health condition. They had an order to have their

international normalized ratio (INR) checked monthly. On a specified date their INR was checked, and the result was above the therapeutic range.

A section of a resident's plan of care was not reviewed or revised until after they sustained an injury. A member of the management team indicated that this was because the home's procedures were not followed, and the resident's physician was not made aware of the lab work.

Sources: A resident's orders, labs, physician progress notes, and interview with a member of the management team.

[741074].

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) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that when a person had reasonable grounds to suspect improper or incompetent treatment or care of a resident resulting in harm or a risk of harm, the suspicion, and the information upon which it was based was reported immediately to the Director.

Rationale and Summary

The licensee has failed to ensure that improper care of a resident was reported immediately to the Director. The incident was reported to the Director several days after.

A member of the management team received an email from a resident's essential caregiver on a specified date. They interpreted this written complaint to be alleging improper/incompetent treatment of a resident resulting in harm or risk of harm to the resident and submitted a critical incident report (CIR) to the Ministry of Long-Term Care on a specified date.

Sources: CIR #2321-000066-23, CIR #2321-000063-23, and interview with a member of the management team.

[741074].