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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Original Public Report

Report Issue Date: November 19, 2024

Inspection Number: 2024-1064-0003

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare St. Catharines, St Catherines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5-8, 2024

The following intake(s) were inspected:

- Intake: #00116308 - Critical Incident (CI): 2321-000030-24 - Neglect of resident by staff.
- Intake: #00116632 - CI: 2321-000031-24 - Improper/Incompetent treatment of resident by staff.
- Intake: #00117520 - CI: 2321-000033-24 - Improper/Incompetent treatment of resident by staff.
- Intake: #00121543 - CI: 2321-000045-24 - Improper/Incompetent treatment of resident by staff.
- Intake: #00128067 - CI: 2321-000058-24 - Fall of resident resulting in injury.
- Intake: #00126011 - CI: 2321-000052-24 - Improper/Incompetent treatment of resident by staff.
- Intake: #00128001 - CI: 2321-000056-24 - Physical abuse resident to resident.

The following intake(s) were completed:

- Intake: #00121976 - CI: 2321-000047-24 - Fall of resident resulting in injury.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 11.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to live in a safe and clean environment.

Residents' Bill of Rights. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to live in a safe and clean environment.

The licensee has failed to ensure that a resident's right to a safe environment was promoted.

Rationale and Summary
On a specific date, a resident was left in the tub room alone during their bath by staff. The staff acknowledged that they knew not to leave a resident alone in the

tub, and acknowledged that the resident's right to a safe environment was not upheld.

Failure to provide the resident with a safe environment had risk of injury or harm to the resident.

Sources: Resident's clinical records, Critical Incident report, the home's internal investigation notes, home's policy titled "Bathing, Showering, and Water Temperature Monitoring", interview with staff.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily used by residents at all times.

Rationale and Summary
On a specific date, a resident was waiting to be transferred after using the washroom. When staff came to check on the resident, they indicated that they had been ringing for help and no one came. Upon further investigation it was noted that the resident's call bell was not working.

Failure to ensure that the home is equipped with a resident-staff communication

and response system that can be easily used by residents at all times diminished the quality of care provided to the resident and put them at risk of not receiving more urgent care should it be required.

Sources: Resident's progress notes, the home's investigation notes for critical incident, and interview with the Assistant Director of Care.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
A staff was passing through a hallway and noticed a resident was falling down on another staff member.

Staff acknowledged that they were aware that the resident required extensive assistance from two staff as per their plan of care for this type of transfer but that they completed the first part of the transfer on their own anyway. Failure to use safe positioning and transferring techniques when assisting the resident resulted in actual harm to the resident.

Sources: Resident's progress notes, completed assessments, the home's

investigation notes for critical incident, and interviews with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident with altered skin integrity was re-assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident was exhibiting altered skin integrity. Their clinical records indicated a weekly skin re-assessment was completed 11 days from the initial skin assessment. The Acting Director of Care (ADOC) acknowledged that weekly skin re-assessments, at minimum of seven days, must be completed.

Failure to re-assess the resident's skin at least weekly posed a potential risk for identifying the worsening of their skin.

Sources: Resident's clinical records and interview with the ADOC.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee has failed to ensure that a resident was provided sufficient changes of their continence care products to remain clean, dry, and comfortable.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director regarding improper care that was provided to a resident. The resident was found incontinent in bed with their bed linens soaked. Additionally, the resident was experiencing altered skin integrity.

The ADOC indicated that the resident wore continence products that required to be changed at sufficient times. They acknowledged the resident was not kept clean, dry, and comfortable at the time of the incident and was not provided continence care as per plan of care.

Failure to ensure the resident was provided sufficient changes to their continence care products resulted in skin breakdown and the resident not remaining dry, clean, and comfortable.

Sources: Resident's clinical records, Critical incident report, investigation notes, and interviews with staff.