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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 8, 2023	
Inspection Number: 2023-1332-0003	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Brampton, Brampton	
Lead Inspector Amanpreet Kaur Malhi (741128)	**Inspector Digital Signature** Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2023.09.11 12:32:31 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28-31, 2023, and September 1, 6, 2023.

The following intake(s) were inspected:

- Intake #00084750, related to staff to resident alleged abuse and improper care
- Intake #00085017, related to falls prevention and management
- Intake #00094916, related to unexpected death of a resident

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to ensure that when they had reasonable grounds to suspect the improper treatment of multiple residents that it was reported to the Director immediately.

Rationale and Summary
A. The home received a complaint through their whistleblower portal expressing concerns about improper care and alleged abuse of multiple residents by multiple staff. However, the Critical Incident (CI) report was not reported to the Ministry until approximately a month later.

B. In accordance with FLTCA, 2021, s. 154 (3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

A student PSW reported an allegation of abuse and improper care towards two residents to PSW #105. PSW #105 did not inform anyone of the allegations of abuse and improper care.

Approximately a month after the leadership team was notified, the home reported those allegations to the Director.

When the home's leadership team and PSW #105 failed to report immediately the complaint of improper care and alleged abuse of residents to the Director, it delayed the investigation process and could have delayed a response from the Director.

Sources: A Critical Incident, Home's Internal Investigation Notes, E-mail with subject title - Complaint requiring investigation: Extendicare Brampton, Interview with Administrator #100 and PSW #105.

[741128]