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

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Original Public Report

Report Issue Date: August 14, 2024
Inspection Number: 2024-1343-0004
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Hamilton, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 25-26 and 29-31, 2024 and August 1-2 and 6-8, 2024
The inspection occurred offsite on the following date(s): August 1 and August 8, 2024

The following intake(s) were inspected:

- Intake: #00116743- Complaint related to prevention of abuse and neglect, infection prevention and control (IPAC), falls prevention and management, skin and wound management, reporting, and staffing.
- Intake: #00117613- Complaint related to resident care and support services, medication management, skin and wound management, falls prevention and management, staffing, and safe and secure home.
- Intake: #00117922- Complaint related to resident care and support services, medication management, prevention abuse and neglect, food and nutrition, and staffing.
- Intake: #00115787- Critical Incident (CI) related to falls prevention and management
- Intake: #00119219- CI related to IPAC.

- Intake: #00119285- CI related to prevention of abuse.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - Based on Assessment of Resident

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)
Plan of care

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure to set out a care for a resident, related to a specified equipment in the plan of care, was based on an assessment of the resident and on the needs and preferences of that resident.

Rational and Summary
A resident had a fall on a specified date resulting in an injury. The care plan at the time of the fall indicated the resident's specific mode of locomotion. Their most recent transfer assessments indicated a specific transfer. Minimum Data Set (MDS) assessment indicated that the resident used a specified equipment for locomotion.

A staff member stated that the resident's specified equipment was in specified location when the resident was discovered by this staff member. A registered staff indicated that the resident used the specified equipment on a specified date when the fall occurred. Another registered staff indicated that the most recent transfer assessment in place prior to fall should say that the resident used the specified equipment.

Sources: Progress notes, Care Plan, assessments, and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

A) The licensee has failed to ensure that the provision of care for specific activities of daily living (ADLs) were documented for a resident.

Rationale and Summary
A resident required specific assistance for their ADLs. Their Documentation Survey Report was reviewed and indicated several care and dates were not documented between specified dates. The Administrator acknowledged that there were missing care dates and stated that all care provided was to be documented.

Sources: A resident's electronic health records (EHR), interview with Administrator, and the home's investigation package.

B) The licensee has failed to document the provision of care related to a specified care set out in a resident's plan of care.

Rational and Summary
A resident's care plan indicated specific interventions.

Documentation Survey Report contained no documentation on providing the specific interventions on several dates and times. Based on the Documentation Survey Report, the Resident Assessment Index (RAI)- Coordinator indicated that specified tasks were used for the documentation of the specific interventions.

Three staff members indicated the specific interventions were provided to the resident on specific dates, but documentation was missed.

Sources: Documentation Survey Report, Progress notes, and interviews with the RAI-Coordinator and staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee of a long-term care home has failed to protect a resident from sexual abuse by another resident.

According to Ontario Regulations (O.Reg.) 246/22 section 2 (1) defines sexual abuse under (b) as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rational and Summary
A review of progress notes indicated that there was an incident of sexual abuse from one resident to another resident. A staff member who discovered the incident, heard the one resident asking the other resident to go away.

The staff member confirmed and witnessed the incident and indicated that the one resident did not experience a negative outcome as a result. The Social Worker (SW) stated that the resident was their usual self after the incident.

Failure to protect a resident from sexual abuse by another resident, put the resident at risk for harm.

Sources: Progress Notes and interviews with staff.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, at minimum, for any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

Rationale and Summary
In accordance with the home's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy, any employee or person who became aware of an alleged, suspected, or witnessed resident incident of abuse or neglect would report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

On a specified date, a resident sustained a skin alteration from an unknown cause. Two days later, a complaint was lodged alleging that the resident's skin alteration was a result of an incident by another resident and was investigated immediately. As per the home's investigation notes, the resident's Power of Attorney (POA) and two staff statements acknowledged that the POA had reported concerns that the

resident attained the skin alteration by another resident on that specified date. There were no clinical records that indicated an alleged incident between the residents or was reported to a supervisor or management on that day.

The Director of Care (DOC) acknowledged that the alleged incident between the residents should have been reported immediately to management as per the zero tolerance of abuse and neglect policy to be investigated.

Failure to ensure that staff immediately reported an alleged incident of abuse as per the home's policy to promote zero tolerance of abuse and neglect, posed a risk of further harm or abuse.

Sources: Residents' clinical records, investigation notes, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting Policy, and interviews with staff.

WRITTEN NOTIFICATION: Complaints Procedure — licensee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to forward a written complaint regarding the care of a resident to the Director as required.

Rationale and Summary
On a specified date, a resident's family member sent an email to the home's Administrator, Director of Care, and a Clinical Lead with concerns regarding the resident's care. The home's Administrator acknowledged the complaint by replying to the email, however, failed to forward the complaint immediately to the Director.

The Administrator acknowledged that they should have forwarded the written complaint to the Director, as required.

Sources: Email complaint on a specified date, LTCH.net portal, and interview with the Administrator.

WRITTEN NOTIFICATION: Doors in a Home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
On a specified date and time, a resident entered a specified room in a non-

residential area and fell. A staff member confirmed they found the resident on the floor and called for help. A registered staff responded to the call and assessed the resident. Both the staff and the home's DOC could not verify how the resident entered the non-residential area. The door to the non-residential area was locked by a numerical keypad that required a four-digit pin.

When doors to non-residential areas were not kept closed and locked, there was actual risk to the resident's health and safety when they entered the area unsupervised.

Sources: Observation of the door, review of a resident's clinical record, and interviews with staff.

WRITTEN NOTIFICATION: Compliance with Manufacturers' Instructions

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee has failed to ensure that staff used a resident's specified equipment in accordance with the manufacturers' instructions.

Rationale and Summary
During the course of inspection, a resident was observed using a specified equipment with a specific part to the equipment intact. In accordance with the

home's manufacturer manual for the specified equipment, the specific part to the equipment were used to prevent the equipment from tipping over when in a specific position and needed to be adjusted to a safe height.

On a specified date, a resident had a fall where the resident was found on the floor in the specified equipment that had fallen backwards. As per the resident's risk management records, the resident's specified equipment was noted to be in a specific position with the specific part of the equipment raised. A staff explained that when assessed, the resident's specific part of the equipment was not adjusted to a safe height and was in a position halfway up. The Falls Lead acknowledged that the resident's specific part of the equipment was not engaged and not safely in place at the time of the fall.

Failure to ensure that staff used the specified equipment in accordance with the manufacturer's instructions posed a risk to resident safety and falls.

Sources: A resident's clinical records, specified equipment Manual, and interviews with staff.

WRITTEN NOTIFICATION: General Requirements

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident

under the skin and wound care program, including assessments and the reassessments were documented.

Rationale and Summary
On a specified date, a resident sustained a skin alteration. The initial and subsequent weekly re-assessments for the skin alteration were conducted by registered staff. However, a review of the resident's skin assessments conducted from specified dates, indicated multiple skin assessment tools with missing documentation that did not include the type of skin impairment, location, description, measurements, and to identify if the injury was the same, improved, deteriorated, or healed. The Skin and Wound Lead acknowledged that the resident's weekly skin assessments were incomplete as there were missing information documented.

Failure to document a resident's assessment of their skin alterations posed a risk in not identifying the improvement or worsening of their skin condition.

Sources: A resident's clinical records, Skin and Wound Program: Wound Care Management, and interview with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that the falls prevention and management program provided strategies to reduce or mitigate falls, including the monitoring of residents.

Rationale and Summary
A resident had a history of falls and was initiated on the home's Falling Leaf program on a specified date, for falls prevention and management. The home's policy stated that residents who were on the Falling Leaf program required frequent monitoring at a specified frequency to ensure safety, assist with care needs, and prevent unsafe transfers particularly at shift change. The resident sustained a fall on a specified date. An intervention was added in the resident's plan of care to be monitored on a specified frequency on a specified date. A Clinical Lead acknowledged the resident should have been initiated on a monitoring program when they were started on the Falling Leaf program.

There was a risk to the resident's health and safety when required interventions for falls prevention and management were not initiated.

Sources: Review of a resident's clinical record, home's policy Falls Prevention and Management Program, and an interview with staff.

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for

falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

A) The licensee has failed to ensure that when a resident had a fall, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
On a specified date, a resident had a fall. The resident's clinical records indicated that a post-fall assessment was not completed for the fall and was acknowledged by the Falls Lead.

Failure to ensure a post fall assessment was completed posed a risk for not identifying any potential harm and implementation of interventions for a resident.

Sources: A resident's clinical records, Falls Prevention and Management Program, and interview with staff.

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

Rationale and Summary
A resident had a fall on a specified date. A Clinical Lead confirmed that a falls assessment was not completed post fall and should have been completed.

When a falls assessment using a clinically appropriate assessment instrument that was specifically designed for falls was not completed, there was actual risk that injuries sustained to the resident as a result of the fall were not assessed.

Sources: Review of a resident's clinical record and interview with staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 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 of has failed to ensure that a resident exhibiting altered skin integrity was reassessed at least weekly by an authorized person described in subsection (2.1), when clinically indicated.

Rational and Summary
A resident had a fall on a specified date, and as a result, the resident was sent to a hospital with an injury. Progress notes indicated that the resident was readmitted to the long-term care home from the hospital on a specified date. The Skin-Head-to-Toe Assessment date indicated that the resident's skin assessment was conducted only at the time of re-admission, identifying specific skin alterations. A review of the Assessments section in the Point Click Care (PCC) software, progress notes and the Daily Reports did not identify any other weekly skin and wound assessment conducted for the resident's skin alterations, which was confirmed by a registered staff.

The RAI-Coordinator indicated that weekly skin assessments were to be documented in the Assessment tab in the PCC software in the Skin-Weekly

Impairment Skin Integrity Assessment form, once an Order in the PCC was initiated and electronic Medication Administration Record (eMAR) task was created, which was not completed for the resident after their initial assessment.

Sources: The Assessments section in the PCC software, the Skin-Head-to-Toe Assessment, progress notes and the Daily Reports, and interviews with a resident and staff.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that when a resident exhibited skin condition that is likely to require or respond to nutrition intervention, they were assessed by a Registered Dietitian (RD) who is a member of the staff of the home.

Rationale and Summary
A resident sustained a skin alteration on a specified date. A referral to the home's RD was not completed. A Clinical Lead acknowledged a referral was not completed and should have been completed.

When a resident exhibited a skin condition that was likely to require or respond to a nutrition intervention and a referral to the home's RD was not completed, there was risk to the resident's health and safety as nutritional and hydration needs were not being met.

Sources: Review of a resident's clinical record and an interview with staff.

WRITTEN NOTIFICATION: Pain Management

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident fell on a specified date. The resident indicated pain and was administered medication for pain relief at a specified time. At a later specified time, the resident stated that the pain had increased, and the medication was ineffective. The resident was sent to the hospital within the hour. A Clinical Lead confirmed that the resident was not assessed using a clinically appropriate assessment instrument, when the resident's pain was not relieved by initial interventions.

When a resident was not assessed using a clinically appropriate assessment instrument after their pain was not relieved by initial interventions, there was risk to the resident's health resulting from an unresolved and increasing pain.

Sources: Interview with a Clinical Lead and a review of a resident's clinical record.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard, issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement (b) any standard issued by the Director with respect to infection prevention and control.

The IPAC Standard for Long-Term Care Homes (LTCHs), section 3. Surveillance, indicated that the licensee had to ensure that on every shift, the symptoms were recorded and that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Rational and Summary
A resident had a fall on a specified date and resulted in an injury. Their progress

notes dated on a specified date, indicated that the resident had a specified infection which possibly contributed to their fall.

The resident's progress notes and Daily Reports identified that the resident was on isolation from specified dates, due to specific symptoms exhibited. On specified dates, the resident's symptoms were not documented on night shifts. The resident's Temperature Summary indicated that the resident's temperature was not documented on night shifts for the same period of time.

During an interview, a registered staff indicated that a resident, who experienced specified symptoms, was to be monitored every day and every shift, their symptoms, including temperature, were to be documented.

Sources: Progress notes, Daily Reports, Temperature Summary and interview with staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or

The licensee has failed to ensure that when dealing with a complaint made concerning the care of a resident, they included an explanation of what the licensee had done to resolve the complaint.

Rationale and Summary
A complaint was lodged regarding concerns of a resident's skin alteration as a result from an alleged incident from another resident. The complainant advised they had brought forward their complaint to the home and did not receive a follow-up.

On review of the home's Complaint Logs, records indicated on a specified date, the complainant had made a verbal complaint regarding their concerns for the resident's skin alteration. The home immediately investigated the complaint, and the allegations were unfounded. The results of the investigation and actions taken were discussed with the resident's POA and not the complainant. The home's complaint investigation form had a documented record of a response to the POA but had no indications a response to the complainant was provided. The DOC acknowledged they did not follow-up with the complainant.

As a result of the home not providing a response to the person who made a complaint, they were unaware that the resident's concerns were being addressed.

Sources: Resident clinical records, Complaint Investigation Form, and interview with DOC.

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that a controlled substance was stored in a separate locked area within the medication cart.

Rationale and Summary
On a specified date, a registered staff found a controlled substance tablet in a medication cup in a resident's medication box in the medication cart. The Extendicare Management of Insulin, Narcotics and Controlled Drugs Policy stated that controlled substances were to be stored in a separate, locked area within the locked medication cart. The registered staff confirmed that the controlled substance was not stored in a separate, locked area within the locked medication cart.

Failure to ensure controlled substances were stored in a separate locked area in a locked medication cart increased the risks for potential harm to residents and theft.

Sources: A resident's EHR, Extendicare Management of Insulin, Narcotics and Controlled Drugs Policy, and interview with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s.

140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
On a specified date, a registered staff found medications in a medication cup in a resident's medication box in the medication cart. Investigations revealed that the medications were the resident's medications for a specified date and time and that the medications were signed for but not administered. The registered staff confirmed that the medications were not administered in accordance with the directions for use specified by the prescriber.

Failure to administer the medications in accordance with the directions for use specified by the prescriber, could have had a negative impact on a resident's health.

Sources: A resident's EHR, medication incident report, and interview with staff.