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: September 25, 2023	
Inspection Number: 2023-1369-0005	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Mississauga, Mississauga	
Lead Inspector Patrishya Allis (000762)	**Inspector Digital Signature** Patrishya Allis Digitally signed by Patrishya Allis Date: 2023.09.26 11:21:26 -04'00'
Additional Inspector(s) Colleen Lewis (000719) was present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 14-15, 18-19, 2023

The following intake was inspected: #00096003 - Fall of resident resulting in left hip fracture.

The following intakes were completed in this inspection: Intake: #00084391, #00089403, #00090054, #00091335 were related to falls and injury.

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

Infection Prevention and Control
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 (1) (a)

The licensee has failed to ensure there was a written plan of care that sets out supervised toileting was required for a resident to reduce the risk of falls.

Rationale and Summary
A resident had a fall that resulted in a hospital transfer. A registered practical nurse (RPN) confirmed the resident was left unattended while toileted. A RPN and two Personal Support Workers (PSW) confirmed the resident was confused, was at risk for raising up from the toilet seat, and required close supervision while toileted. The resident's care plan prior to the fall did not indicate supervision when toileted was required.

The Assistant Director of Care (ADOC) confirmed that the resident was at high risk for falls, and supervision when toileted should have been implemented and written in the care plan.

Failure to implement and document the required supervision when toileting in the care plan placed the resident at moderate risk for falling.

Sources: Interviews with the ADOC and other staff, and the resident's care plan.

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WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure a protective device was placed on a resident at all times as specified in their plan of care.

Rationale and Summary
A resident's care plan identified they required a protective device to be always worn. During resident observations, no protective device was identified on the resident. The resident's family member showed the Long-Term Care Homes Inspector the additional clean protective devices available for use, which were stored in resident's bedside cabinet.

A PSW acknowledged that no protective device was placed on resident, and confirmed the protective device was removed and placed in laundry.

Failure to ensure the protective device was worn by the resident placed them at moderate risk for injury.

Sources: Interview with the PSW, resident observations, and the resident's care plan.

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