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

Public Report

Report Issue Date: January 27, 2025

Inspection Number: 2025-1377-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Halton Hills, Georgetown

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 14- 27, 2025.

The following intake(s) were inspected:

- Intake: #00131127 - Unwitnessed fall of resident resulting in injury.
- Intake: #00131907 - Resident to resident physical abuse.
- Intake: #00132510 - Staff to resident neglect during transfer resulting in skin tears.
- Intake: #00134458 - Improper care of a resident during shower.
- Intake: #00134859 - Allegations of potential abuse by staff towards a resident
- Intake: #00136019 - Complainant related to resident care services and support, including abuse and neglect by staff.

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

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

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Responsive Behaviours
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 (11) (b)
Plan of care
s. 6 (11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

The licensee has failed to ensure that when the care set out in the plan was not effective for a resident, that different approaches were considered in the revision of the plan of care.

There was no new interventions tried during a seven month period where a resident had several falls. A specific intervention was recommended during one of the post falls assessments, however it was not implemented.

When the falls interventions for the resident were ineffective and different approaches were not tried, this may have contributed to the resident's subsequent fall and injuries.

Sources: Resident's care plan, post-fall assessments, quarterly and annual review assessment, and progress notes, and interviews with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee failed to ensure appropriate actions were taken in response to every alleged, suspected or witnessed incident of abuse or neglect.

According to the long term-care home's Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences-policy, in cases where the allegation of abuse or neglect is made against an employee, management will immediately advise the employee that they are being removed from the work schedule, with pay, pending investigation.

The abuse policy was not followed when a resident reported that they were handled roughly during care.

Sources: Interviews with staff and record review of Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences policy.

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 has failed to ensure that a resident was provided with safe transferring techniques.

A resident was transferred by staff using a method that did not align with their assessed care needs.

The resident was injured during the transfer and sustained skin tears.

Sources: Interviews with the resident and staff, the resident's care plan, progress notes, the homes internal investigation and Safe Lift and Transfer policy, and disciplinary letters to staff.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee failed to ensure the implementation of skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

According to the long-term care home's Skin and Wound Program: Prevention of Skin Breakdown, the direct care staff observe the residents head to toe skin condition during the provision of personal care and promptly report verbally any changes (e.g. redness, bruises, skin tears) to the nurse.

A Personal Support Worker (PSW) stated that a resident sustained skin injuries after they were provided care. The PSW did not promptly report to the nurse when the skin impairment was first identified.

When the skin concern was not reported promptly, it led to a delay in assessment of the resident.

Sources: Interview with staff, and review of resident's clinical records.