

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu  
de la Loi de 2007 sur les  
foyers de soins de longue  
durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

Hamilton Service Area Office  
119 King Street West 11th Floor  
HAMILTON ON L8P 4Y7  
Telephone: (905) 546-8294  
Facsimile: (905) 546-8255

Bureau régional de services de  
Hamilton  
119, rue King Ouest 11<sup>ième</sup> étage  
HAMILTON ON L8P 4Y7  
Téléphone: (905) 546-8294  
Télécopieur: (905) 546-8255

**Amended Public Copy/Copie modifiée du rapport public**

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<b>Report Date(s)/ Date(s) du Rapport</b>	<b>Inspection No/ No de l'inspection</b>	<b>Log #/ No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 05, 2021	2021_689586_0005 (A1)	019195-20, 019196-20, 021978-20, 022339-20, 022366-20, 025805-20, 000426-21	Complaint

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**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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**Long-Term Care Home/Foyer de soins de longue durée**

Extendicare Hamilton  
90 Chedmac Drive Hamilton ON L9C 7S6

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

Amended by JESSICA PALADINO (586) - (A1)

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**Amended Inspection Summary/Résumé de l'inspection modifié**

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**Error in resident number.**

**Issued on this 5 th day of February, 2021 (A1)**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 05, 2021	2021_689586_0005 (A1)	019195-20, 019196-20, 021978-20, 022339-20, 022366-20, 025805-20, 000426-21	Complaint

**Licensee/Titulaire de permis**

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**Long-Term Care Home/Foyer de soins de longue durée**

Extendicare Hamilton  
90 Chedmac Drive Hamilton ON L9C 7S6

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

Amended by JESSICA PALADINO (586) - (A1)

**Amended Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 21, 22, 25, 26, 27 and 28, 2021.

**The following intakes were inspected concurrently:**

**Log #000426-21 (complaint) and #025805-20 (Critical Incident System [CIS] - 2858-000019-20) related to an incident of resident abuse;**

**Log #021978-20 (complaint) and #022339-20 (CIS - 2858-000017-20) related to an injury of unknown cause and staffing levels;**

**Log # 022366-20 (complaint) related to infection prevention and control (IPAC) and staffing levels;**

**Log # 019196-20 (follow-up) related to resident abuse; and,**

**Log # 019195-20 (follow-up) related to plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Support Services Manager (SSM), Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, residents and families.**

**During the course of the inspection, the inspector(s) completed an IPAC assessment, observed resident care and reviewed resident health records, internal investigation notes, internal compliance plans, staff schedules, and relevant policies and procedures.**

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

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**Accommodation Services - Housekeeping  
Falls Prevention  
Infection Prevention and Control  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Sufficient Staffing**

**During the course of the original inspection, Non-Compliances were issued.**

- 3 WN(s)**
- 0 VPC(s)**
- 1 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**

**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

<b>REQUIREMENT/ EXIGENCE</b>	<b>TYPE OF ACTION/ GENRE DE MESURE</b>	<b>INSPECTION # / NO DE L'INSPECTION</b>	<b>INSPECTOR ID #/ NO DE L'INSPECTEUR</b>
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2020_587129_0006	506

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.)</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (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. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

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durée

(A1)

1. The licensee has failed to ensure that a resident was protected from verbal abuse by staff.

Ontario Regulation 79/10, s. 2 (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

On an identified date in 2020, a resident was verbally abused by a staff member in the home. Upon the home's internal investigation, evidence was identified to prove this occurrence. This incident resulted in negative outcome toward the resident. The DOC confirmed the actions taken by the staff member met the definition of verbal abuse.

Sources: CIS #2858-000019-20, resident health record, internal investigation notes, the licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect Program' (last updated June 2020) and interview with the resident and the DOC. [s. 19. (1)]

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

(A1)

**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

- s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident's written plan of care included the planned care for the resident.

According to interviews with multiple staff members, a resident would display a particular behaviour. This information was provided to the home by the resident's family upon admission.

The resident's written plan of care, which front line staff use to direct care, did not include this information until nine months later, after the resident had a traumatic incident in which they were found displaying this behaviour. This was confirmed by the DOC.

If behavioural information is not included in the plan of care, staff may not be aware of the resident's needs.

Sources: CI #2858-000017-20, resident clinical health record, the home's internal investigation package and interviews with PSWs #108, #110, #111, #112, #113, RPN #114, RN #107, RN #109 and the DOC. [s. 6. (1) (a)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**



**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**

**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the incident occurred.

A resident was found to have a significant injury and was sent to the hospital. They returned with specific interventions to be put into place to manage the injury.

According to the home's internal investigation notes, and confirmation by the DOC, the incident was not reported to the Director until seven days later.

Sources: CI #2858-000017-20, resident clinical health record, the home's internal investigation package, interview with resident #002's SDM and interview with the DOC. [s. 107. (3) 4.]

**Issued on this 5 th day of February, 2021 (A1)**



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**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Long-Term Care Operations Division  
Long-Term Care Inspections Branch  
Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée

**Amended Public Copy/Copie modifiée du rapport public**

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**Name of Inspector (ID #) /  
Nom de l'inspecteur (No) :** Amended by JESSICA PALADINO (586) - (A1)

**Inspection No. /  
No de l'inspection :** 2021\_689586\_0005 (A1)

**Appeal/Dir# /  
Appel/Dir#:**

**Log No. /  
No de registre :** 019195-20, 019196-20, 021978-20, 022339-20,  
022366-20, 025805-20, 000426-21 (A1)

**Type of Inspection /  
Genre d'inspection :** Complaint

**Report Date(s) /  
Date(s) du Rapport :** Feb 05, 2021(A1)

**Licensee /  
Titulaire de permis :** Extendicare (Canada) Inc.  
3000 Steeles Avenue East, Suite 103, Markham,  
ON, L3R-4T9

**LTC Home /  
Foyer de SLD :** Extendicare Hamilton  
90 Chedmac Drive, Hamilton, ON, L9C-7S6

**Name of Administrator /  
Nom de l'administratrice  
ou de l'administrateur :** Pilar Henderson

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**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following  
order(s) by the      date(s) set out below:

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

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l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

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**Order # /**

**No d'ordre:** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /**

2020\_587129\_0006, CO #002;

**Lien vers ordre existant:**

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be complaint with LTCHA, s. 19 (1).

Specifically, the licensee must ensure that the identified resident is protected from verbal abuse by staff.

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Grounds / Motifs :**

1. The licensee has failed to ensure that a resident was protected from verbal abuse by staff.

Ontario Regulation 79/10, s. 2 (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

On an identified date in 2020, a resident was verbally abused by a staff member in the home. Upon the home's internal investigation, evidence was identified to prove this occurrence. This incident resulted in negative outcome toward the resident. The DOC confirmed the actions taken by the staff member met the definition of verbal abuse.

Sources: CIS #2858-000019-20, resident health record, internal investigation notes, the licensee's policy, 'Zero Tolerance of Resident Abuse and Neglect Program' (last updated June 2020) and interview with the resident and the DOC.

An order was made by taking the following factors into account:

Severity: The verbal abuse by the PSW resulted in actual harm to the resident.

Scope: This was an isolated case as no other incidents of abuse were identified during this inspection.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 19 (1) of the LTCHA. This subsection was issued as a CO on August 25, 2020, during inspection #2020\_587129\_0006 with a compliance due date of December 18, 2020. No other COs were issued to the home in the past 36 months. (586)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :**

Feb 12, 2021

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

**Ordre(s) de l'inspecteur**

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

**Ordre(s) de l'inspecteur**

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2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector**

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section 154 of the *Long-Term  
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2007, c. 8

**Ordre(s) de l'inspecteur**

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foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5 th day of February, 2021 (A1)**

**Signature of Inspector /  
Signature de l'inspecteur :**

**Name of Inspector /  
Nom de l'inspecteur :**

Amended by JESSICA PALADINO (586) - (A1)

**Order(s) of the Inspector**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**Service Area Office /  
Bureau régional de services :**

Hamilton Service Area Office