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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: June 17, 2025

Inspection Number: 2025-1343-0002

Inspection Type:
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): June 3, 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 2025

The following intake(s) were inspected:

- Intake: #00142543 - Critical incident [CI] 2858-000008-25 - related to medication administration
- .Intake: #00144734 - [CI] 2858-000008-25 - related to medication administration.
- Intake: #00145637 - [CI] 2858-000016-25 - related to falls prevention and management

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident had a risk identifier present as specified in their written plan of care during the initial observation on a set date. This observation was acknowledged by staff, who indicated that a risk identifier should have been available in their room to inform staff of their risk.

Later on that day, a risk identifier was observed above the resident's bed.

Sources: Observation, and review of resident's plan of care.

Date Remedy Implemented: June 3, 2025

WRITTEN NOTIFICATION: Right to freedom from abuse and neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to ensure that a resident's right to freedom from neglect was upheld by staff when they were observed on three different occasions without their intervention in place. Staff did not ask the resident if they wanted the intervention during the observations, nor were there any efforts made to encourage the resident. The resident was transferred by one staff, knowingly that the resident did not have their intervention in place.

Another staff was also aware through their own observation that the resident's intervention was not in place, however they did not take any steps to correct the situation or to determine if this was a personal choice of the resident.

The above identified staff members indicated that the resident did not have their intervention in place over a two day period.

Sources: Observations, care plan, progress notes, and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that a resident had a risk prevention device as outlined in their written plan of care.

On three different occasions within a two-day period, the resident was observed without their risk prevention device.

A staff member noted that when they observed that the resident was not wearing their risk prevention device on a set date, they did not make any attempt to correct the situation.

Sources: Observations, resident plan of care, and staff interview.

The licensee has failed to ensure that a resident received hourly monitoring on each shift as specified in their plan of care following an incident debriefing on a set date.

Sources: Resident's progress notes and their plan of care.

WRITTEN NOTIFICATION: Plan of care

NC #004 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.

The licensee has failed to ensure that the provision of care outlined in a resident's written plan of care was documented, as it relates to the resident not wearing their risk prevention protective device.

One staff member noted that when they attended the resident's room on a set date at a set time to provide care, they observed that the resident was not wearing their risk prevention device, but did not document the information.

Sources: Observations, care plan and staff interview.

WRITTEN NOTIFICATION: Duty to protect

NC #005 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 has failed to protect a resident from physical abuse by another resident.

According to section 2 of the Ontario Regulation (246/22), physical abuse is defined as "the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitements d’ordre physique”)".

On a set date, a resident sustained an injury when they were pushed by another resident.

Sources: Critical Incident Report [CI: 2858-000014-25], residents progress notes, and the home’s internal investigation notes.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 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 any standard issued by the Director with respect to infection prevention and control was complied with.
Section 9.1 (b), of the IPAC Standard, specified that the home's hand hygiene shall include, but not limited to, the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact.
The home's hand hygiene policy states that all employees should Perform hand hygiene at the point of care during the 4 Moments of Hand Hygiene and before, between and after activities that may result in cross contamination.

On a set date, a staff member did not observe hand hygiene before and after administering medications to residents in the dining room during med pass.

Sources: Observation, hand hygiene policy, medication administration policy, Interview with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under

subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident and their substitute decision makers (SDMs) were made aware of the outcome of the home's internal investigation upon completion, as it relates to the alleged incident of physical abuse against them.

Sources: Resident's progress notes.

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 134 (2)
Monitored dosage system
s. 134 (2) The monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities.

The licensee has failed to ensure that they promoted the ease and accuracy of the administration of drugs to a resident and supported monitoring and drug verification activities on a set date, when the medication were not counted at the beginning of the shift.

Sources: Progress notes, prescribers digiorder, electronic medication administration record (emar), interview with staff.

WRITTEN NOTIFICATION: Administration of drugs

NC #009 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, when a staff member administered medication from memory without referring to the current order and the resident received an extra dose.

Sources: Progress notes, prescribers digiorder, emar, medication record, interview with staff.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health, after discovering that there was a medication incident on a set date.

Sources: Progress notes, prescribers digiorder, interview with staff, DOC's confirmation email.