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: May 20, 2025
Inspection Number: 2025-1064-0002
Inspection Type: Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare St. Catharines, St Catharines

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: May 1-2, 5-9, 13-15, 2025.

The inspection occurred off-site on the following date: May 12, 2025.

The following intakes were inspected:

- Intake #00138186/ Critical Incident (CI) #2321-000003-25 and Intake #00143636/ CI #2321-000012-25 were related to prevention of abuse and neglect.
- Intake #00138653/ CI #2321-000004-25 and Intake #00145445/ CI #2321-000014-25 were related to care and services.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

Section two (2) of the Ontario Regulation (O. Reg.) 246/22 defined emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences".

Section 2 of O. Reg. 246/22 defined physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain." Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

A) The licensee failed to protect a resident from emotional abuse by a co-resident, when the co-resident made threatening remarks and gestures toward the resident.

Sources: Resident clinical records, critical incident (CI) 2321-000003-25, risk management module, interviews with the resident, staff and leadership team.

B) The licensee failed to protect a resident from abuse by staff.

i) A staff member stated they witnessed another staff use physical force toward a resident during care. The home's leadership team acknowledged that the specified action by the staff was considered abusive.

ii) Staff reported they witnessed the same staff member under example i) providing rough care to a resident. A skin assessment identified skin impairment consistent with the witness information.

Sources: Resident clinical records, long-term care home's (LTCH) investigation notes, interviews with staff and the leadership team.

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 that appropriate action was taken in response to every alleged, suspected or witnessed incident of abuse of a resident.

i) Staff members alleged staff to resident abuse and rough care toward multiple residents. The home's investigation did not include all the named residents and action was not taken to determine if abuse had occurred.

ii) Staff alleged staff to resident emotional abuse and appropriate action was not taken in response to the allegation, as specified by the home's written policy to

promote zero tolerance of abuse and neglect.

Sources: LTCH's investigation notes, zero tolerance for abuse and neglect policy, interviews with staff and the leadership team.

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee failed to ensure that a resident's individualized plan to promote and manage continence was implemented when two continence products were applied on a specified shift when the resident was assessed as requiring one product.

Sources: LTCH's investigation notes, continence product lists, continence care program, interviews with staff and the leadership team.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee failed to ensure that matters referred to in subsection (1) were integrated into the care provided to a resident. Specifically, written technique to minimize and respond to the resident's responsive behaviours were not integrated into their care when they demonstrated behaviours during specified care activities.

Sources: Resident clinical record, LTCH's investigation records, CI 2321-000004-25, staff training records, interviews with the leadership team.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A) The licensee failed to implement an intervention that was in place to prevent or minimize a resident's responsive behaviours.

Sources: Resident observations, resident clinical record, interviews with the resident and leadership team.

B) The licensee failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviour that was known to direct care staff.

Sources: Resident clinical record, LTCH's investigation notes for CI 2321-000012-25, interviews with staff and the leadership team.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. i.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,

In making a report to the Director under subsection 27 (2) of the Act, the licensee failed to include the names of all residents involved in the incident, with respect to an alleged incident of abuse that led to the report.

Sources: Resident clinical records, LTCH's investigation file, CI 2321-000012-25, interviews with staff and the leadership team.

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