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

Original Public Report

Report Issue Date: April 14, 2023
Inspection Number: 2023-1377-0003
Inspection Type: Complaint Follow up Critical Incident System
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Halton Hills, Georgetown

Lead Inspector	**Inspector Digital Signature**
Janet Groux (606)	Janet Groux Digitally signed by Janet Groux Date: 2023.04.26 15:51:36 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 7-11,13-15, 2023.
The inspection occurred offsite on the following date: March 13, 2023.

The following intakes were inspected:

- Intake #00019088 regarding Follow-up to CO #01-O. Reg. 246/22 - s. 102 (2) (b)
- Intake #00019560 regarding the home's Resident Abuse and Neglect Program; and
- Intake #00021580 regarding concerns about a resident's care.

Previously Issued Compliance Order(s)

Order #001 from Inspection #2023-1377-0002 related to O. Reg. 246/22 - s. 102(2)(b) was complied.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1
O. Reg. 246/22, s. 54 (3)

The licensee has failed to ensure that a specified falls prevention device was readily available for a resident.

Summary and Rationale:

A specified falls prevention device belonging to a resident was not working during a shift.

The staff said the specified falls prevention device was usually available in the home but during that shift, they were not able to find one. They said the staff checked on the resident during the shift while the specified falls prevention device was not available to ensure the resident's safety.

The ADOC said that the resident was provided the specified falls prevention device that was working the next shift.

Sources: an observation, and interviews with staff. (606)

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)(b)

The licensee has failed to ensure that the staff and others involved in the different

aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Summary and Rationale:

The home's Falls Prevention and Management Program said a referral to the physiotherapist (PT) for further assessment and interventions would be initiated if a resident has had multiple falls; and that the interdisciplinary team would proactively identify and address individual and environmental risk factors and causes of falls.

The resident fell multiple times and sustained injuries from some of their falls when they had a change in their condition. Staff said they noticed the resident had cognitively and physically declined.

The PT said they were not aware of the residents cognitive and physical decline. A PT assessment was not completed until the resident had already fallen multiple times.

Failure for the home's multidisciplinary team to collaborate with each other regarding a resident's health status caused a delay in addressing the resident's falls risks and may have contributed in the resident having subsequent falls.

Sources: a resident's clinical records, and interviews with the PT and nursing staff. [606]

WRITTEN NOTIFICATION: Reporting and Complaints
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a complainant's written letter which outlined concerns about a resident's care was submitted to the Director.

Summary and Rationale:

A resident's clinical records identified that the resident's relative submitted a written letter to the home regarding concerns about the resident's care.

The ADOC said they did not submit the written letter to the Director as required.

Sources: a resident's clinical records, and interview with staff. [606]

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)1

The licensee has failed to ensure to comply with the falls prevention and management program for a resident.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee is required to ensure the falls prevention and management program to reduce the incidence of falls and the risk of injury, must be complied with.

Specifically, staff did not comply with their Falls Prevention and Management Program, which directed registered staff to complete a Fall Risk Assessment, as clinically indicated, or for any fall with serious injury or a resident with multiple falls.

Summary and Rationale:

A resident had a change in their health status after they were diagnosed with a medical condition and fell multiple times.

The resident's clinical records did not identify that a falls risk assessment was completed for the resident after they fell multiple times during the time they had a change in their health status. A registered staff said a falls risk assessment should be completed after a resident falls.

Sources: a resident's clinical records, the home's policy, "Falls Prevention and Management Program, and interviews with staff .[606]