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
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Original Public Report

Report Issue Date: September 19, 2023	
Inspection Number: 2023-1343-0005	
Inspection Type: Complaint	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Hamilton, Hamilton	
Lead Inspector Klarizze Rozal (740765)	**Inspector Digital Signature** Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2023.10.06 09:53:14 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6-8 and 11, 2023

The following intake(s) were inspected:

- Intake: #00093372 - for a Complaint related to concerns with medication management (diabetes management), falls prevention and management, skin and wound care and cooling requirements.

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

Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that a resident's drugs were stored in an area or a medication cart that were secured and locked.

Rationale and Summary
During the course of inspection, a resident's room was observed with prescribed topical drugs unattended on the resident's bedside table.

The resident's electronic medical records (EMR) indicated no orders for self-medication administration or to keep drugs in their room. A registered staff acknowledged that the resident was incapable for self-medication administration and that their topical treatment should not have been left in their room unattended.

Failure to ensure that a resident's topical drugs were stored in an area or medication cart that were secured and locked, posed a risk to the resident and other residents for adverse drug events.

Sources: Observations, a resident's EMR, Medication Management Policy, and interview with staff. [740765]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

A) The licensee has failed to ensure that any actions taken with respect to a resident under the falls prevention and management program including responses to interventions were documented.

Rationale and Summary
A resident's Point of Care (POC) records under their falls prevention were reviewed. Between specified dates there were missing documentation on multiple days and shifts, to indicate that

the resident's device checks were conducted. The Director of Care (DOC) acknowledged that there were missing staff documentation on the POC tasks and stated that all task documentation should be completed.

Sources: A resident's POC records and an interview with the DOC. [740765]

B) The licensee has failed to ensure that any actions taken with respect to a resident under the skin and wound program including responses to interventions were documented.

Rationale and Summary
A resident's POC records indicated multiple missing documentation for their skin and wound monitoring and interventions on different shifts and dates on specified dates. The Director of Care (DOC) acknowledged that there were missing staff documentation on the POC tasks and stated that all task documentation should be completed.

Failure to document a resident's responses to interventions may have resulted in interventions not being implemented or provided.

Sources: A resident's POC records and an interview with the DOC. [740765]

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

The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting a resident.

Rationale and Summary
On a specified date, a resident was transferred with a mechanical lift with two staff assistance to their wheelchair. The residents' wheelchair fell backward when the resident was being positioned, resulting in the resident sustaining a fall.

A staff member acknowledged they did not check the resident's wheelchair prior to transferring. The Resident Assessment Instrument (RAI) Coordinator acknowledged that staff should have ensured the resident's wheelchair was safe prior to transferring and positioning the resident into their wheelchair.

Failure to ensure that staff used safe transferring and positioning techniques when assisting a resident increased their risks for injury and harm.

Sources: A resident's EMR, Safe Resident Handling Procedure, and interviews with staff. [740765]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was re-assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
A resident exhibited altered skin integrity from specified dates and had orders for weekly re-assessments for their altered skin. The resident's records indicated six weeks of weekly skin re-assessments not completed between specified dates. The Director of Care (DOC) acknowledged that weekly skin re-assessments, at minimum of seven days, must be completed on altered skin.

Failure to re-assess a resident's skin at least weekly posed a potential risk for identifying the worsening of their skin.

Sources: A resident's EMR, Skin and Wound Management Program: Wound Management Policy, and interview with the DOC. [740765]