Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2014	2014_331595_0006	S-000256-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE KIRKLAND LAKE
155 GOVERNMENT ROAD EAST, P.O. BAG 3900, KIRKLAND LAKE, ON, P2N-3P4

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

MARINA MOFFATT (595)

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): August 19 & 20, 2014

Ministry of Health and Long-Term Care Logs reviewed: S-000256-14, Log # 000349-14

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Staff and Non-Registered Staff.

During the course of the inspection, the inspector(s) conducted clinical record reviews, reviewed various policies and procedures, and observed care provided to residents.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

It was alleged that on three separate occasions staff member #102 transferred resident #001 without the aide of another staff member.

On August 19, 2014 Inspector #595 conducted a clinical record review of resident #001's health care record. In the care plan (dated July 29, 2014) and the kardex it stated that the resident required the use of a mechanical lift for transferring, required 2 staff for the transfer, and that the yellow padded sling was to be used. In the resident's most recent MDS assessment (dated July 20, 2014) it was indicated that the resident required to be lifted mechanically and was totally dependent upon staff for transferring.

On August 19 and 20, 2014 Inspector #595 conducted interviews with staff members #102, 103 and 105. All staff members confirmed that resident #001's care plan identified the use of a mechanical lift with two staff members.

In June 2014, the home conducted an investigation into the alleged incident which identified that staff member #102 stated that they did not follow the resident's care plan as indicated.

As a result, the care set out in resident #001's care plan was not provided. [s. 6. (7)]

Issued on this 21st day of August, 2014

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