



**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**

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2016	2016_391603_0002	001655-16, 027731-15, 026631-15	Critical Incident System

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

SYLVIE LAVICTOIRE (603)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 25, 26, 2016

During the course of the inspection, the Inspector directly observed the delivery of care and services to residents, staff to resident interactions, conducted a daily tour of resident home areas, reviewed resident health care records, reviewed various home policies and procedures, and inspected three critical incident reports sent to the Ministry of Health and Long-Term Care as follows: one related to Controlled Substance missing/unaccounted, one related to Abuse/Neglect, and one related to Incident with injury/hospital transfer/significant change in status.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Staff (RNs, RPNs), Personal Support Workers, Administrative Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Medication

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)

1 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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 the resident as specified in the plan.

A Critical Incident was reported to the Director which indicated that on a certain date, resident #001 was found on the dining room floor. The fall was unwitnessed and upon a head to toe assessment, the resident was observed to be alert with no injuries. After the fall, the resident was wandering on the unit with staff present and later settled in bed. At 1845hrs, resident #001 was found in bed with emesis on their bed and clothing. They were responsive but their pupils were fixed. Resident #001 was transferred to the hospital via ambulance and later died. The home was informed that the cause of death was from an injury.

Inspector reviewed resident #001's care plan and noted a focus of locomotion on/off unit and the interventions included: supervision required for resident to move between locations with no aid and since the resident wandered, staff were to provide supervision, encouragement and cuing but no physical support to assist resident to ambulate.

An interview with the DOC revealed that on the day of the incident, the resident had been brought to the dining room for dinner and was left alone until a staff member heard a noise and found the resident on the dining room floor. The fall was unwitnessed. The DOC explained that in this case, it was the home's expectation that someone should have been supervising the resident's actions as was identified in the care plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents



Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

- 1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
- 2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
 - i. a breakdown or failure of the security system,**
 - ii. a breakdown of major equipment or a system in the home,**
 - iii. a loss of essential services, or**
 - iv. flooding.**O. Reg. 79/10, s. 107 (3).**
- 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
- 4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
- 5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

A Critical Incident (CI) was reported to the Director on a certain date, which indicated that 17 days earlier, RN #102 reported that a controlled substance ampule easily broke open when pressure was applied to the scored area. The ampule was removed from circulation and the DOC would assess the next day. On the next day, the DOC assessed the ampules and when they opened the box containing the ampules, one ampule broke open without being touched. The Police was notified and concluded that there was no tampering of the ampules.

According to the CI, 5 days later, RPN #103 reported that there was a clear, hard substance that they were unable to remove when cleaning the medication cart on a certain level. The Administrator and Clinical Coordinator #104 confirmed that there was a hard substance on the cart. They reassessed the controlled substance ampules and several of them appeared to have the same clear, hard substance on the scored area, which could not be removed. It appeared to be a glue like substance. The police was notified but did not feel it required immediate attention, but would have the officers, who replied to the initial incident, follow up on their next shift.

On a certain date, the home's Pharmacy Consultant, Administrator, Director of Care, and police reviewed and tested the ampules' openings. At that time, they all agreed that the ampules appeared tampered with as they all broke off very easily, and the substance inside was foreign to the manufacture's material. On a certain date, three ampules were sent to the Forensic Sciences department to identify substance. Seven days later, a statement obtained from the Police confirmed that the substance on the ampules was glue.

Inspector interviewed the Administrator who could not explain why the home had not reported the incident on the date it was identified that there was tampering with the ampules. Instead the home reported the incident, seven days later. [s. 107. (3)]



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Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the Director is informed no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance, to be implemented voluntarily.

Issued on this 25th day of February, 2016

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

Original report signed by the inspector.



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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8

**Health System Accountability and Performance Division
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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SYLVIE LAVICTOIRE (603)

Inspection No. /

No de l'inspection : 2016_391603_0002

Log No. /

Registre no: 001655-16, 027731-15, 026631-15

Type of Inspection /

Genre

Critical Incident System

d'inspection:

Report Date(s) /

Date(s) du Rapport : Feb 24, 2016

Licensee /

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

LTC Home /

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

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Jennifer Kasner

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and
Long-Term Care**

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007*, S.O. 2007, c.8

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Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8



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Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

Order # /

Ordre no : 001

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the care set out in the plan of care is provided to residents as specified in the plan. The Plan will include the following:

1. A process to ensure that the care set out in the plan of care for each resident is provided to the resident as specified in the plan.
2. An auditing process that will identify when staff are not providing care as specified in the plans, so that corrective action can be taken.
3. A multidisciplinary process to ensure clear communication between front line staff, so that the care is provided to the residents as specified in the plans.

This plan shall be submitted in writing to Sylvie Lavictoire, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564 3133 or email sylvie.lavictoire@ontario.ca. This plan must be submitted by March 8, 2016, with full compliance by March 22, 2016.

Grounds / Motifs :



Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
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An interview with the DOC revealed that on the day of the incident, the resident had been brought to the dining room for dinner and was left alone until a staff member heard a noise and found the resident on the dining room floor. The fall was unwitnessed. The DOC explained that in this case, it was the home's expectation that someone should have been supervising the resident's actions as was identified in the care plan.

LTCHA, 2007 S.O. 2007, s. 6. (7) was issued previously four times as WN or VPC during Inspection # 2015_376594_0028, and WN during Inspection #2014_331595_0006. The scope of this issue was isolated, the severity was actual harm, and there was previous on-going non-compliance with this legislation. (603)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Mar 22, 2016



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section 154 of the *Long-Term Care
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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance
Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of February, 2016

**Signature of Inspector /
Signature de l'inspecteur :**

**Name of Inspector /
Nom de l'inspecteur :** Sylvie Lavictoire

**Service Area Office /
Bureau régional de services :** Sudbury Service Area Office