Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2021	2021_894684_0004	012702-21	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Kirkland Lake
155 Government Road East Kirkland Lake ON P2N 3P4

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

SHELLEY MURPHY (684)

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): November 1-4, 2021.

The following intake was inspected during this Complaint inspection:
One complaint intake that was submitted to the Director regarding nutrition/hydration and medication concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (A-DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers (Hskg), residents and families.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, the home's internal investigation notes, and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of their plan of care.

A complaint was submitted to the Director, which indicated that the Power of Attorney (POA) was not made aware of changes to a resident's medications.

Inspector reviewed a resident's physician orders and progress notes and was unable to locate where their POA was made aware of the new medication orders; this was confirmed by the Acting Director of Care (A-DOC). This did not allow the resident/POA to have input into the plan of care.

Sources: Complaint intake; home's policy Physician/Nurse Practitioner Orders, RC-16-01 -14, review of the resident's chart, interview with the A-DOC. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Medication Incident and Reporting policies and procedures included in the medication management system were complied with.

O. Reg. 79/10, s. 114 (2), requires written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
O. Reg. 79/10, s. 135 (2)(a) requires that all medication incidents and adverse drug reactions are documented, reviewed and analyzed.

Specifically, staff did not comply with the home's policy and procedure "Medication Incident and Reporting", RC-16-01-19.

The home's Medication Incident and Reporting Policy indicated the following:
-Communicate and document medication incident/adverse drug events.
-Review all medication incident/adverse drug events and corrective action plans at the home's Medical/Professional Advisory Committee.

A registered staff member confirmed that the medication error involving a resident was not noted on the Medication Incident Summary and there was no Medication Incident Report completed for the error.

Sources: Complaint intake; home's policy Medication Incident and Reporting, RC-16-01-19, review of the Medication Incident Summary and Medication Incident Reports, and the interview with a registered staff member. [s. 8. (1) (b)]

Issued on this 18th day of November, 2021

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

Original report signed by the inspector.