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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: September 13, 2023	
Inspection Number: 2023-1176-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kirkland Lake, Kirkland Lake	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.09.27 08:41:49 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 14-15, 2023.

The following intakes were completed in this inspection:

- Two intakes related to falls with injury.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care - When Reassessment, Revision is Required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised, when their care needs changed related to falls prevention.

Rationale and Summary
A resident had a fall that resulted in injury. A fall risk assessment was completed after the fall which indicated that the resident's risk for falls had changed. No additional interventions were added to the resident's care plan.

The resident had another fall that resulted in injury; the care plan was not revised at the time.

Staff members and the Director of Care (DOC) all acknowledged that at the time of the falls, the resident's care plan should have been reviewed and revised by the registered staff to reflect the change in the resident's care needs related to falls.

Failing to review and revise the resident's care plan when their care needs had changed, placed the resident at increased risk for falls with injury.

Sources: A resident's clinical health record and minutes of the home's Falls Committee meeting; and interviews with the DOC and other staff members.

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WRITTEN NOTIFICATION: Plan of Care - Duty of Licensee to Comply with Plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
A resident was identified at risk for falls. The care plan for the resident identified specific falls interventions to be in place.

Observations of the resident revealed that the interventions were not in place.

A staff member acknowledged that they noticed the interventions were not in place but did not check the resident's care plan to see if changes had been made.

The DOC confirmed that the interventions were required to be implemented as identified in the resident's care plan; that staff were always required to check the care plan for direction related to a resident's care needs.

Failing to ensure that the falls interventions were in place as per the care plan, placed the resident at risk for further injury related to falls.

Sources: Observations of a resident; review of a resident's clinical health record; and interviews with the DOC and other staff.

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WRITTEN NOTIFICATION: Falls Prevention and Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the falls prevention and management program and complete fully the clinical monitoring record for 72 hours for a resident.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b) the licensee was required to ensure that the home's falls prevention and management program was complied with. Specifically, staff did not comply with the licensee's Head Injury Routine (HIR) protocol.

Rationale and Summary
The home's fall prevention program required staff to complete a post-fall assessment after each fall and complete the clinical monitoring record for 72 hours after an unwitnessed fall.

A resident had several falls. The home indicated that clinical monitoring for a head injury was required for the falls. Review of the resident's clinical monitoring records revealed that for the fall incidents, the HIR clinical monitoring record was initiated but not completed for the full 72 hours as required by the program.

The DOC acknowledged that the HIR monitoring routine was not always completed by staff as outlined

in the home's policy.

Failing to ensure that the home's HIR monitoring routine was completed by staff as required, placed the resident at risk that a potential change in their condition may not have been immediately identified.

Sources: A resident's clinical health record, fall risk management reports, and the home's Falls Prevention and Management program; and interviews with the DOC and other staff members.

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WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (6)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was promptly notified when the resident sustained an injury.

Rationale and Summary
A resident sustained an injury that required transfer to hospital for further assessment. The SDM as identified in the resident's health record, was not notified of the injury.

The DOC and Administrator confirmed that an error had been made; the SDM identified in the resident's health care record had not been notified right away.

Failing to notify the resident's SDM as required, may have resulted in the SDM not being made aware of the injury and taking actions if necessary.

Sources: A resident's clinical health record and the home's complaint investigation form; and interviews with the DOC, Administrator, and other staff members.

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WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under subsection 82 (7) of the Act.

Rationale and Summary
O. Reg 246/22, s. 261 (1) 1. indicated that falls prevention and management training for all staff who provided direct care to residents, was to be provided.

The home's Falls Prevention training record for 2022, confirmed that several direct care staff had not completed their annual training in falls prevention.

The DOC acknowledged that annual training was required and should have been completed by all direct care staff.

Failing to ensure that staff were trained in falls prevention and management on an annual basis, placed residents at risk of not receiving the most current and relevant approaches to falls prevention and management.

Sources: Review of the Fall Prevention training record for 2022; and interviews with the DOC and other staff members.

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