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

Modified Public Report

Report Issue Date: August 16, 2024

Inspection Number: 2024-1176-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kirkland Lake, Kirkland Lake

MODIFIED INSPECTION SUMMARY

The report has been modified to remove information that was originally included in error.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29 to August 2, 2024.

The following intake(s) were inspected:
-One Critical Incident (CI) intake related to an alleged improper/incompetent care of a resident by a staff member that resulted in an injury.
-One complaint intake related to care concerns of improper care which resulted to a fall incident of a resident with an injury.
-One complaint intake related to wound care concerns of a resident.

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration

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

Infection Prevention and Control
Safe and Secure Home
Palliative Care
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bill of Rights - Breach of Confidentiality

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure that residents' personal health information (PHI) was kept confidential in accordance with the Personal Health Information Protection Act, 2004, related to a home's office door not being closed and locked.

Sources: A complaint; review of resident's records; the home's internal investigation, and interview with the DOC.

WRITTEN NOTIFICATION: Plan of Care - SDM Involvement

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) participated fully in the development and implementation of the resident's nutrition plan of care which was not communicated.

Sources: A complaint intake; review of resident's records and the home's policy, interview with staff members and the DOC.

WRITTEN NOTIFICATION: Lift and Transfer

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident as per their care plan and safe lift and transfer protocol.

Sources: A complaint intake; review of resident's records; review of the home's policy; interview with staff members and the DOC.

WRITTEN NOTIFICATION: Skin and Wound - no cleansing and dressing intervention

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure that a resident who exhibited altered skin integrity had specified interventions to prevent infection.

Sources: A complaint intake; review of resident's records; the home's policy, and interview with staff members and the WCL.

WRITTEN NOTIFICATION: Critical Incident - Late Reporting

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (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 (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure that the Director was informed no later than one business day when a resident had a fall incident, sustained an injury, and was sent to the hospital for further medical care.

Sources: CI report; review of resident records; review of the home's policy, and interview with the DOC.

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