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
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Public Report

Report Issue Date: January 13, 2025

Inspection Number: 2025-1176-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Extendicare (Canada) Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 6-10, 2025
The inspection occurred offsite on the following date: January 13, 2025

- One intake was inspected related to a Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;

The licensee has failed to ensure that the written plan of care for two residents outlined their planned care related to a specific health condition.

Sources: Residents' electronic health records; and an interview with a registered staff member.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that clear direction was provided to staff and others who provided direct care to a resident.

Sources: A resident's care plan; and interviews with a resident, the Director of Care

(DOC), and other staff members.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident's plan of care related to a specific assessment, was provided as specified in their plan of care.

Sources: A resident's electronic health record; and an interview with a registered staff member.

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the care provided to a resident, as outlined in the plan of care, was documented during a specified period of time.

Sources: A resident's electronic health record; and interviews with a resident and staff members.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (3)
Continuous quality improvement committee
s. 166 (3) Every continuous quality improvement committee has the following responsibilities:
1. To monitor and report to the long-term care home licensee on quality issues, residents' quality of life, and the overall quality of care and services provided in the long-term care home, with reference to appropriate data.
2. To consider, identify and make recommendations to the long-term care home licensee regarding priority areas for quality improvement in the home.
3. To coordinate and support the implementation of the continuous quality improvement initiative, including but not limited to, preparation of the report on the continuous quality improvement initiative.

The licensee has failed to ensure that the home's continuous quality improvement (CQI) committee fulfilled its responsibilities under Ontario Regulation 246/22 of the Fixing Long-Term Care Act, 2021.

At the time of the inspection, the home was unable to provide meeting minutes demonstrating that the CQI committee had met to complete the required tasks.

Sources: Observations; review of the CQI meeting minutes provided by the home, meeting minutes from Residents' Council, and licensee's policy titled, "CQI Committee"; and interviews with the DOC, Resident Program Manager, and Interim Administrator.