Ontario

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 8, 2013	2012_021111_0034	O-001457-12	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 KAWARTHA LAKES
125 Colborne Street East, LINDSAY, ON, K0L-2V0

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 2012

A finding of non-compliance for O.Reg. 79/10 s. 52(2) Pain Management was issued but issued under a complaint inspection that was completed at the same time under log # 001331.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, and the physician.

During the course of the inspection, the inspector(s) reviewed the health record of a deceased resident and reviewed the homes policy on pain management.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A critical incident report was submitted for an injury resulting in transfer to hospital. An identified resident sustained the injury while being transferred.

Review of the health record for an identified deceased resident confirmed the resident sustained an injury during a transfer by a non-registered staff member. The transfer devices were not applied at the time of the injury. The resident subsequently developed pain but did not receive pain management for a period of three days. There was also a delay in treatment but no explanation for the delay.

The licensee failed to ensure that an identified resident was cared for in a manner consistent with the needs of the resident. [s. 3. (1) 4.]

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 to ensure that all current resident experiencing pain are cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. A critical incident report was submitted for an injury resulting in transfer to hospital. An identified resident sustained the injury while being transferred.

Review of the health record for an identified deceased resident confirmed the resident sustained an injury during a transfer by a non-registered staff member. The transfer devices were not applied at the time of the injury.

The licensee failed to ensure that staff used safe transferring techniques/devices when assisting the resident. [s. 36.]

Issued on this 8th day of January, 2013

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

L. Brown