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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 6, 2017	2017_505103_0027	009141-17, 011207-17	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 KINGSTON
309 QUEEN MARY ROAD KINGSTON ON K7M 6P4

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

DARLENE MURPHY (103)

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): July 5, 2017

Log #009141-17 (resident fall)
Log #011207-17 (resident fall)

During the course of the inspection, the inspector(s) spoke with a resident, a Registered Nurse (RN), a Physiotherapy assistant (PTA), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector made resident observations, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure an injury, for which the resident was taken to hospital, but the licensee was unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition, was reported to the Director no later than three business days after an occurrence.

Resident #002 was admitted to the home on an identified date and had identified diagnoses. On an identified date, the resident had an unwitnessed fall and sustained an injury. The staff assessed the resident and transferred resident #002 to the hospital for further assessment. The resident was returned to the home a few hours later and staff continued to assess the resident’s neurological vital signs.

RN #103 was interviewed and indicated upon return to the home, resident #002 was noted to be lethargic and this was initially attributed to the administration of an identified medication while in the hospital emergency department. The RN stated it became apparent two days following the fall, that the resident’s overall condition had changed in that the resident had a decline in mental acuity, required feeding by staff, and required a mechanical lift for all transfers. The RN indicated the Nurse Practitioner had assessed the resident on an identified date and was unable to definitively determine the cause of the resident's status. The resident was subsequently deemed to be palliative and deceased nine days after the fall.

The home submitted a critical incident report to the Director (MOHLTC) two days after the resident's death. The licensee failed to ensure an injury, for which the resident was taken to hospital, but the licensee was unable to determine within one business day whether the injury resulted in a significant change in the resident's health condition, was reported to the Director no later than three business days after the occurrence. [s. 107. (3.1)]

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Issued on this 6th day of July, 2017

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

Original report signed by the inspector.