Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 9, 2022	2022_505103_0010	001880-22, 002660-22, 003872-22	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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): March 3, 4, 7, 2022.

Log #001880-22 (CIS #2616-000001-22), Log #002660-22 (CIS #2616-000002-22) and Log #003872-22 (CIS #2616-000003-22)-resident falls that resulted in injuries.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Registered Physiotherapist (PT), housekeeping staff, the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, critical incidents submitted regarding these incidents, home's investigation into the alleged incidents, staff education records related to lifts/transfers, and made resident and staff observations related to Infection, Prevention and Control practices (IPAC) related to provision of care, dining and activities.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's care related to toileting and transfers was provided as outlined in the plan of care.

A resident was assisted by a staff member to use the commode. During the transfer, the resident lost their balance, fell onto the floor and sustained an injury. The staff member acknowledged they were aware of the resident's plan of care related to transferring, but did not have immediate access to a second staff member to assist. The resident's plan of care related to transfer and toileting at the time of this incident required the extensive assist of two staff throughout the transfer and use of the commode.

Sources: resident's plan of care, interview with staff member. [s. 6. (7)]

2. The licensee failed to ensure a resident's care related to continence and bed mobility was provided as outlined in the plan of care.

A resident was being assisted by a PSW with continence care. The PSW indicated they were changing the resident's brief and placing a sling under the resident to prepare them in getting out of bed. During the provision of care, the resident rolled off the bed, onto the floor and sustained an injury. The resident's plan of care related to continence care and bed mobility at the time of this incident was total assistance of two staff.

Sources: resident's plan of care, interview with PSW. [s. 6. (7)]

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 care is provided as outlined in resident plans of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or strategy, the policy or strategy was complied with.

In accordance with O. Reg 79/10, s. 49 (1), the falls prevention and management program must provide for strategies to reduce falls. The licensee failed to ensure the written policy to ensure the safe placement of a sling for mechanical lifts was complied with.

Specifically, a PSW failed to comply with the licensee's policy, "Mechanical Lifts Procedure", LP-01-01-03, last updated August 2017. The policy stated two staff are required to insert/apply slings used for mechanical lifts. The PSW attempted to independently apply the sling under a resident which resulted in the resident rolling off of the bed, onto the floor and sustaining an injury.

Sources: Mechanical Lifts policy and interview with the PSW and DOC. [s. 8. (1)]

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 the home's Mechanical lifts policy is complied with regarding the placement of slings, to be implemented voluntarily.

Issued on this 10th day of March, 2022

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

Original report signed by the inspector.