Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 17, 2022
Inspection Number 2022_1126_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Extendicare (Canada) Inc.

Long-Term Care Home and City
Extendicare Kingston

Lead Inspector
Amber Lam #541

Additional Inspector(s)
Anna Earle #740789

Inspector Digital Signature
Amber Lam
Digitally signed by Amber Lam
Date: 2022.08.17 11:55:05 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 9, 10, 11 and 15, 2022

The following intake(s) were inspected:

- Intake # 009550-22 related to staffing
- Intake # 011745-22 related to a fall with injury
- Intake # 010531-22 related to an improper transfer
- Intake # 010220-22 related to a fall with injury
- Intake # 015028-22 related to a transfer to hospital with a significant change in condition

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

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s.102(8)*

The licensee has failed to ensure that a staff member participated in the implementation of the infection control program.

Rationale and Summary

A staff member was providing care in a resident room. There was a sign on the door indicating contact precautions for a resident in the room. When the PSW exited the room, inspector confirmed they had provided care to the resident who was on contact precautions and they should have been wearing a gown. The Director of Care confirmed that when a resident is on contact precautions, a gown must be worn.

Sources: Interview with staff and DOC, observations and signage on resident's room.

[541]