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

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Original Public Report

Report Issue Date: January 11, 2023	
Inspection Number: 2022-1126-0002	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kingston, Kingston	
Lead Inspector Kayla Debois (740792)	**Inspector Digital Signature** Kayla L Debois Digitally signed by Kayla L Debois Date: 2023.01.12 14:20:53 -05'00'
Additional Inspector(s) Stephanie Fitzgerald (741726)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 19-22, 2022

The following intake(s) were inspected:

- Intake: #00003757-[CI: 2616-000017-22] Fall of resident, sustained an injury
- Intake: #00007911-[CI: 2616-000019-22] Fire outside of the home, residents evacuated

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

Infection Prevention and Control
Falls Prevention and Management
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b).

The licensee has failed to ensure that a standard issued by the Director with respect to support for residents to perform hand hygiene prior to receiving meals was complied with.
In accordance with additional requirement 10.4 (h) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022), the Licensee shall ensure that the hand hygiene program also includes support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

Rationale and Summary:
On a day in December 2022, the Inspector observed a staff member assisting residents to the dining room for meal service. The staff member was observed seating several residents at their table. Hand hygiene was not offered to any resident upon entry, or once seated, prior to meal service at the table. Additional staff were observed to transfer residents into the dining room, without offering assistance for hand hygiene, prior to the meal being served. Interviews with staff confirmed hand hygiene should be offered prior to entry to the dining room for meals, or offered at the table. An interview with a member of the management team confirmed that current practice is to complete hand hygiene once seated at the table.

There was a risk of illness and infection to the residents, when support for hand hygiene was not offered prior to meal service.

Sources: Observation occurring on a day in December 2022, Interview with a staff member and a member of the management team.

[741726]

WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that their written policy related to falls prevention and management

was complied with for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that their written policy related to falls prevention and management for residents is complied with. Specifically, staff did not comply with the licensee's Falls Prevention and Management Program #RC-15-01-01; Post fall management procedure section 1 (d.): complete a Clinical Monitoring Record, if a resident hits their head or is suspect of hitting head (e.g., unwitnessed fall); or Prevention of falls section 5: screen all residents with a change in condition that could potentially increase the resident's risk of falls/fall injury.

Rationale and Summary:
On a day in August 2022, a resident had fallen, hitting their head. Immediate assessment showed pain, and no obvious injury. The resident was later transferred to hospital, and sustained an injury due to the fall. A review of the Falls Program clarified that the Clinical Monitoring Record (CMR) must be completed at specific time intervals. A review of the resident's clinical record showed only one clinical monitoring record being completed, however notes did show three other documented assessments. Interviews with multiple staff, and a member of the management team, confirmed that the CMR should have been completed for the resident. The Inspector could not locate evidence that a CMR had been completed for the intervals specified within the program.
A review of the resident's clinical record revealed a falls assessment was not completed upon their return from hospital. A review of the Falls Program clarified that a falls assessment was required with a significant change in status, which was confirmed during an interview with a staff member.

By not ensuring the written policy related to falls prevention and management was complied with, the resident was at an increased risk of injury.

Sources: Resident's electronic and hard copy health record; Falls Prevention and Management Program RC-15-01-01 revised January 2022; Interviews with a member of the management team and other staff members.

[741726]

WRITTEN NOTIFICATION: Doors in the home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that the kitchen door in a non-residential area is kept closed and

locked when not supervised by staff.

Rationale and Summary:

On a day in December, Inspectors #740792 and #741726 observed the door to the kitchen open at the end of the activity hallway. This hallway is a non-residential area separated by fire doors that are not equipped with a locking mechanism. The kitchen door was equipped with a keyhole lock but was not locked at the time of the inspection. There were no staff members supervising in the immediate area and there were no residents in this hallway at the time.
During an interview with a member of the management team, they stated that the kitchen is not to be accessed by residents. They stated the kitchen door is kept unlocked and open during the day when staff are present and is locked in the evening when they leave. They stated the kitchen could pose risk to a resident if they entered the kitchen unsupervised.

By not ensuring that all doors leading to non-resident areas of the home are locked, unsupervised residents may wander into the area, posing risk of injury to the resident.

Sources: Interview with a member of the management team.

[740792]