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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 14, 2015	2015_391603_0015	S-000381-14, S-000869-15, S-000550-14, S-000556-14	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 KIRKLAND LAKE
155 GOVERNMENT ROAD EAST P.O. BAG 3900 KIRKLAND LAKE ON P2N 3P4

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

SYLVIE LAVICTOIRE (603)

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): May 11, 12 , 2015

During the course of the inspection, the inspector directly observed the delivery of care and services to residents, conducted tours of the resident room areas, reviewed resident health care records, reviewed various home policies and procedures, and reviewed critical incident reports sent to the Ministry of Health and Long-Term Care.

During the course of the inspection, the inspector(s) spoke with Director of Care, Personal Support Workers, Office Manager and Residents

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of any staff members who were present at the time of the incident.

Inspector #603 reviewed a Critical Incident Report submitted to the Director. The Critical Incident Report indicated that a person reported resident abuse when they noted 4 finger marks on the resident's body. The incident report failed to identify the names of the staff members who were present at the time of the alleged abuse. An amended report also failed to report the names of the staff members present. Inspector #603 reviewed the home's investigation report which failed to identify the full names of the staff members present at the time of the alleged incident. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included the names of any staff members who were present at the time of the incident.

Inspector #603 reviewed a Critical Incident Report submitted to the Director. The Critical Incident Report indicated that resident #011 stated that a staff member was rough with them on one evening. The report failed to identify the name of the staff member involved in the alleged abuse. Inspector #603 reviewed the home's investigation report which did identify the staff member involved in the alleged incident. [s. 104. (1) 2.]

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Inspector #603 reviewed a Critical Incident Report submitted to the Director. The Critical Incident Report indicated that a Respiratory Outbreak was declared August 15, 2014 after 3 residents presented with similar respiratory symptoms of : hoarse voice, nasal drainage/congestion, non productive cough and fever. According to the report, the outbreak was declared on August 15, 2014, however the report was not filed until August 19, 2014. Inspector #603 interviewed S#100 who explained that the reason the home did not declare the outbreak sooner was because it only involved residents and not the staff. Inspector #603 reviewed the home's policy on Declaring an Outbreak which indicated that: If there are 2 residents OR staff with similar symptoms within 24 hours, Registered staff is to suspect an outbreak and report CIS (Critical Incident System) to MOH via website (https://www.ltchomes.net). If after hours notify by calling the MOH After-Hours Line phone # 1-800-268-6060 and complete the CIS. (Only Admin, DOC or CC can do this). If DOC or CC completing online form - ensure the Admin signs a copy. [s. 107. (1)]

Issued on this 14th day of May, 2015

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

Original report signed by the inspector.