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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
| --- | --- | --- | --- |
| May 19, 2021 | 2021_615759_0013 | 002115-21 | 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 Kirkland Lake
155 Government Road East Kirkland Lake ON P2N 3P4

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

KEARA CRONIN (759)

## 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 10-14, 2021.**

**The following intake was inspected upon during this Critical Incident System (CIS) Inspection:**
**- One intake related to an alleged incident of neglect of a resident.**

**Complaint Inspection #2021_615759_00012 was conducted concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Maintenance Supervisor, Housekeepers, and residents.**

**The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.**

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

**During the course of this inspection, Non-Compliances were issued.**
**3 WN(s)**
**2 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 20. Policy to promote zero tolerance**

**Specifically failed to comply with the following:**

**s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2020, indicated that "Extendicare is committed to providing a safe and secure environment in which all residents are treated with dignity and respect and protected from all forms of abuse and neglect at all times".

A PSW left a resident unattended in a specified location. Although there was no injury to the resident, this incident placed the resident at an actual risk.

The investigation notes indicated that the PSW was in violation with the home's policies and procedures and that due to the seriousness of the incident, it was considered abuse and neglect.

The Administrator confirmed that the staff did not comply with the prevention of abuse and neglect program.

Sources: Interviews with a PSW, the Administrator, and other staff; a CIS report; the home's investigation notes, and the policy titled "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last updated June 2020. [s. 20. (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 that the written policy to promote zero tolerance of abuse and neglect of resident is complied with, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a PSW used safe transferring techniques while assisting a resident using a mechanical lift.

The homes policy titled "Mechanical Lifts LP-01-01-02" indicated that two staff were required at all times when performing a mechanical lift.

A PSW transferred a resident using a mechanical lift without assistance from an additional staff member. Although the resident was not harmed, this action placed the resident at an actual risk.

Sources: Interviews with a PSW, the Administrator, and other staff; the home's investigation notes; a CIS report; the homes policies titled "Mechanical Lifts LP-01-01-02" and "Mechanical Lifts Procedure LP-01-01-03". [s. 36.]

***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 that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect an incident of alleged abuse or neglect towards a resident, that resulted in a risk of harm, was immediately reported to the Director.

There was an incident of alleged abuse and neglect towards a resident as they were left unattended in a specified location for a period of time. This incident was not reported to the Director until the next day, when a Critical Incident (CI) report was submitted.

The Administrator confirmed that this incident was reported to the Director late as it was reported the next day.

Sources: Interviews with the Administrator and other staff; a CIS Report; the homes investigation notes; policy titled "Critical Incident Reporting (ON) RC-09-01-06" last updated June 2020; policy titled "Zero Tolerance of Resident Abuse and Neglect Program: Response and Reporting RC-02-01-02". [s. 24. (1)]

**Issued on this 19th day of May, 2021**

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

**Original report signed by the inspector.**