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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 10, 11, 13, 17, 18, 2012	2012_099188_0034	Critical Incident

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nursing Staff (RN/RPN), the Environmental Services Manager, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed health care records and various policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. Inspector reviewed the health care record including plan of care for resident #006. Inspector noted that a section relating to transfers identifies the resident requires the assistance of one staff to transfer. Inspector noted the same document in a section relating fall prevention strategies identifies the resident requires the assistance of two staff to transfer. Inspector noted this was conflicting and unclear direction. Inspector spoke with staff #101 who confirm unclear direction was provided and identified that the resident requires two staff for all transfers. Staff #101 further identified that they would update the plan of care to clearly identify the proper level of assistance required by the resident. The licensee failed to ensure that the written plan of care provides clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]
2. Inspector reviewed the health care record including plan of care for resident #005. Inspector noted that paper copies of the resident's care plan kept at the nursing station identifies the resident requires the assistance of three staff for all transfers using a total mechanical lift. Inspector noted the electronic copy identifies that the resident requires the assistance of two staff for all transfers using a total mechanical lift. There is conflicting and unclear direction between the printed copy and electronic copy of the resident's care plan. Inspector spoke with staff #102 who confirmed that only two staff are required and proceeded to update the printed copy to reflect the current information. The licensee failed to ensure that the written plan of care provides clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O. 2007, c.8, s.6(1)(c)]

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 ensuring the written plan of care for each resident provides clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

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. Inspector reviewed critical incident report. Inspector noted that resident #005 sustained a fall while being transferred in a total mechanical lift which resulted in a transfer to hospital. Inspector spoke with the Administrator who identified that the staff did not apply the sling properly to the lift during the transfer and this resulted in the resident sustaining a fall from the lift. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O.Reg. 79/10, 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 ensuring staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Inspector reviewed the health care record for resident #007. Inspector noted that the resident sustained a fall. Inspector was unable to locate a post-fall assessment completed following the resident's fall. Inspector spoke with staff #101 who confirmed the home's policy that a post-fall assessment must be completed following every fall and was also unable to locate a completed post-fall assessment for the resident following the fall. The licensee failed to ensure that when a resident has fallen, the resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [O.Reg. 79/10, s.49(2)]

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 ensuring when a resident has fallen, the resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Inspector reviewed critical incident report in which a resident was missing for less than three hours without injury. Inspector noted this incident was reported outside of the one business day reporting time frame. The licensee failed to ensure the Director is informed no later than one business day after the occurrence of the incident. [O.Reg. 79/10, s.107 (3)(1)]

Issued on this 18th day of September, 2012

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