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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 8, 2014 | 2014_339579_0015 | S-000340-14 | Resident Quality Inspection |

**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 KAPUSKASING
45 ONTARIO STREET, P.O. BOX 460, KAPUSKASING, ON, P5N-2Y5

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

JANET MCNABB (579), GILLIAN CHAMBERLIN (593), VALA MONESTIMEBELTER (580)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): August 26, 27, 28, 2014, September 2, 3 and 4th, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care/Infection Control Contact, Registered Nursing Staff, Personal Support Workers (PSW), the Nutrition Manager, the Activity Lead, the Office Coordinator, the maintenance staff, family members and residents.**

**During the course of the inspection, the inspector(s) reviewed resident health records, various policies and procedures, walked through resident home areas and observed staff to resident interactions.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

**Findings of Non-Compliance were found during this inspection.**

| 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 | Legendé<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. 6. Plan of care**

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

**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; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. On September 3rd, 2014 after supper and on September 4th, 2014 after breakfast, Inspector #580 observed resident #3858 not able to undo the wheelchair seat belt. Staff #120, staff #121 and the Administrator stated that the resident was able to remove the seat belt previously. Inspector #580 reviewed resident #3858's care plan dated August 6, 2014 which states that the resident has a seat belt on their chair to remind them not to get up by themselves and that the resident is able to unbuckle the belt by themselves. Inspector #580 found no restraint orders, restraint consent or restraint assessment in the resident's chart.

The licensee has failed to 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 [s. 6. (1) (c)]

2. Inspector #579 interviewed family member #113 who stated that they had to ask if changes were made to resident #3815's breakfast routine recently. They were present at breakfast one day and noticed a different supplement was being offered to resident #3815. The substitute decision maker/family member #113 was not notified of any change.
Further in the interview with family member #113 they reported that the home knows

they are available at all times for phone calls for notifying when there are changes but this seems to not be happening as it did in the past.
Family member #113 stated to inspector #579 that the home doesn't keep the family informed and recently there was a medication change for resident #3815 that they didn't know about until the nurse presented with a different pill. Another example was a dining room table change that they couldn't figure out why their family member, resident #3815, was agitated on a certain visit and then during the visit they took resident #3815 to the dining room and saw that they had had a table change. Once the family #113 asked for the table change to be reversed resident #3815 settled. Inspector #579 interviewed staff #111 and they admitted they often don't notify family if a table change is made in the dining room but rather just make them aware when they come in to visit. The nurses might do a table change for various reasons or the Nutrition Manager is the one who would make the decision.

The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

3. On September 3, 2014 Inspector #580 reviewed resident #3815's care plan last reviewed in 2014 which includes the restraint interventions including; checking and evaluating hourly for safety, repositioning and documenting every two hours. The Home's Physical Restraints policy RESI-10-01-01 dated November 2012 and the Physical Restraint Monitoring policy RESI-10-01-04 dated November 2012 state the minimum frequency for release and repositioning is every two hours. The care plan does not mention release of any type of restraint. On September 3, 2014 Inspector #580 reviewed resident #3815's care plan which stated that the resident is to use a restraint while in a wheelchair. The order is for a restraint while in bed. On September 2, 2014 staff #114, told Inspector #580 that the family member removes the restraint of resident #3815, that staff do not go into the room when the family are there, is not sure what the care plan states regarding resident #3815's care, that when resident #3815 is sleeping during the night or during the day, staff #114 does not wake the resident, does not reposition the resident and does not check the restraint. On August 28, 2014 staff #105, told Inspector #580 that they would not reposition the resident when sleeping, and that "I'm bad for that". Staff #114 stated "we are all bad for that (not repositioning the resident when they are sleeping)." On September 3, 2014 Inspector #580 reviewed resident #3815's Restraint Record of a month in 2014 which had no resident response assessment on a day from 0800 to 1200 although it is

documented that the resident was checked for safety and repositioned. On several days throughout the RQI, Inspector #580 observed no staff enter the room while a family member was present to check or reposition the resident, but the Restraint Record shows hourly checking, repositioning, resident response assessment and no removal or application even though the family member had removed the restraint.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

4. Inspector #579 observed on August 28th, 2014 that at the 1030h group exercise resident #3815 was not attending, despite the care plan which identifies exercise attendance, but sitting at the nursing station desk.
Inspector #579 interviewed staff #101 who stated they go get the resident attendees to participate in the group exercises. Inspector #579 did not observe resident #3815 being approached to attend the exercise group.
Inspector #579 did a record review of the annual conference held on August 6th, 2014 for recreation for resident #3815 and it was noted the resident enjoys a variety of activities and takes pleasure in having others around and that family visit daily and are very supportive.
This information is reflective of the care plan entry for this resident's focus for participation in recreation/activity programming.
Inspector #579 interviewed family #113 who stated that the staff try to bring resident #3815 to activities but they return them to their room for fear of risks. Family #113 reported that there is a physiotherapist program for resident #3815 but it isn't very successful as resident #3815 has mobility issues which affects their ability to participate.
The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

***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 providing 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, and that the resident, the SDM, if any, and the designate of the resident / SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care, and that the care set out in the plan of care, specifically related to resident #3815, is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

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

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

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**Findings/Faits saillants :**

1. Inspector #579 reviewed the Registered Staff schedules for 1 months time in 2014. From the 22-24th of the month, 2014 there was no RN (Registered Nurse) on duty for 24 hours each of these days. On another day there is a 4 hour gap in the evening shift of no RN coverage. On 3 other days in the month of 2014 there is no RN scheduled for a 12 hour night shift.
Inspector #579 interviewed the Administrator/DOC who confirmed that these gaps of 24/7 RN coverage noted on the schedules provided were correct and identified having difficulties to find coverage for RN shifts in the upcoming weeks. The Administrator/DOC stated that an RN retired earlier in 2014 and they have not met the 24/7 RN coverage since then despite advertising.
The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3). [s. 8. (3)]

***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 such that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, 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. 11. Dietary services and hydration**

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

**s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).**

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**Findings/Faits saillants :**

1. Inspector #593 did a review of resident #3832's Plan of Care and found that Resident #3832 has been assessed as a risk for choking and requires a certain consistency of fluids for safe swallowing.
Inspector #593 observed August 28, 2014, during the lunch meal service, staff #102 prepare a thickened fluid for resident #3832. Staff #102 was observed to pour the thickener directly into the cup without measuring the quantity and it was also observed that no recipe was followed at this time. This fluid was then observed to be given to resident #3832, Inspector #593 observed the consistency of this fluid to be a specific consistency that was not reflective of what the resident was assessed for. During an interview with Inspector #593, staff #102 advised that resident #3832 is to receive a specific consistency of fluid, however the inspector noted that what was reported was not the same as in the resident's plan of care.
Inspector #593 observed September 02, 2014 during the dinner meal service, staff #118 prepare a thickened fluid for resident #3832. Staff #118 was observed to pour the thickener directly into the cup without measuring the quantity and it was also observed that no recipe was followed at this time. This fluid was then observed to be given to resident #3832, Inspector #593 observed the consistency of this fluid to be not the correct consistency.
During an interview with Inspector #593, staff #118 advised that resident #3832

requires thickened fluids as they were a choking risk, however, staff #118 was unsure what level of thickened fluid resident #3832 required. Staff #118 further advised that they were unsure of whether the home had a policy or procedure on the preparation of thickened fluids.
Inspector #593 observed September 03, 2014 during the afternoon nourishment pass staff #111 prepare a thickened beverage for resident #3832. Staff #111 was observed to pour the thickener directly into the cup without measuring the quantity and it was also observed that no recipe was followed at this time. In addition, a thickened Boost supplement was observed on the supplement cart for resident #3832, texture of this thickened supplement was observed to be a certain consistency that was not reflective of the resident's assessed needs.
During an interview with Inspector #593, staff #104 advised that a recipe sheet is included on the beverage trolleys and staff are required to follow this when preparing a thickened beverage. In addition, staff have previously received training on preparation of thickened fluids and should be following the homes procedure on preparation of thickened fluids.
A review of the home's Diet Types, Textures and Fluid Consistencies policy dated June 2013 found that required documentation in adhering to this policy must include a description of standard diet types, diet textures and fluid consistencies and that the Dietary department must provide the following fluid consistencies: Regular/Thin, Nectar, Honey and Pudding.
On three occasions, the home provided fluids to resident #3832 of the incorrect consistency and as such, the home have failed to provide safe fluids to resident #3832. [s. 11. (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 to ensure that residents, specifically related to resident #3832, are being provided with food and fluids that are safe, specifically related to thickened fluids, and are adequate in quantity, nutritious and varied, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

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

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

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**Findings/Faits saillants :**

1. During the course of the inspection observations by Inspector #593 on the 26th-28th August, 2014 and 2nd-4th September 2014, found that the wooden hand-rails in the resident corridors including both East and West corridors and the corridor entering the dining room were in disrepair. As advised by staff #116 during an interview with Inspector #593, the wooden hand-rails are old and original fixtures of the home and require continued maintenance throughout the year. Staff #116 advised that they sand down the hand rails every Winter and apply a clear finish however at this time, as observed by Inspector #593, the wooden hand rails are heavily scuffed, the finish has been worn off exposing raw wood and cracks in the wood.
Inspector #593 did a review of the homes Maintenance Program Overview Policy dated July 2013 and found that the home should have a maintenance program that includes routine, preventative and remedial maintenance and that preventative maintenance procedure Number 1401 states that the hand rails are required to be secure and in good condition.
During an interview with Inspector #593 September 04, 2014 the homes Administrator advised that the hand rails are old and agreed that they are in poor condition.
As such, the hand rails in the home are currently in poor condition and therefore the home has failed to ensure that the home is maintained in a safe condition and in a good state of repair as stated in the homes policy and as required in the Act. [s. 15. (2) (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 to ensure that the home, furnishings and equipment, specifically the hand rails, are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.**

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**Findings/Faits saillants :**

1. Inspector #593 interviewed staff #116 who advised that they check the windows annually in May: checks that they open and close properly. Staff #116 sometimes removes the cranks in winter so that some residents cannot open the window, as this can be dangerous if it is cold out. Staff #116 advised that the requirement for window openings is that they open no more than 9 inches (approximately 23cm) and that the Extendicare policy is that the windows can open wider than usual because the windows are higher off the ground than 48 inches (approximately 122cm) therefore they are allowed to open wider than usual. [s. 16.]

2. Inspector #593 observed windows in residents rooms which were open more than 15cm. Windows were checked in the following residents rooms and found to open to 20cm: Room 101, 107, 109, 111, 113 and 203.
A review of the homes maintenance procedure number 1166 found that window openings are to be limited to 4 inches or less, which is 10cm.
During an interview with Inspector #593 September 03, 2014 the homes Administrator advised that the homes policy is that the windows should not open more than 4 inches which is 10cm. At this time, the window in room 101 was checked and found to open to approximately 20cm. The homes Administrator further advised that the previous information regarding the Extendicare policy provided by the Maintenance staff #116 was incorrect.
The home has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened by more than 15cm. [s. 16.]

***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 every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

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

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).**

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**Findings/Faits saillants :**

1. On September 2, 2014 staff #106 told inspector #580 that the family requested the use of the restraint and often remove the restraint when they are present, and staff #106 stated that staff often do not check to verify if the restraint is on when the family members are visiting but document that it is on and that they have checked it. On September 2, 2014 staff #114, told Inspector #580 that the family members remove the restraint of resident #3815 and that staff do not go in to the room when the family members are there. Staff #114 also stated that when resident #3815 is sleeping during the night or during the day, staff #114 does not wake the resident, does not reposition the resident and does not check the restraint. On August 28, 2014 staff #105, told Inspector #580 that they would not reposition the resident when sleeping, and that "I'm bad for that". Staff #114 stated "we are all bad for that (not repositioning the resident when they are sleeping)."

The licensee has failed to ensure that the resident #3815 is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. [s. 110. (2) 3.]

2. On September 2, 2014 staff #106 told the inspector that the family requested the use of the restraint and often remove it when they are present, but that staff often do not check in with the resident to see if the restraint is on when the family members are visiting but document that it is on and that they have checked. On September 2, 2014 staff #114, told Inspector #580 that the family members remove the restraint of resident #3815; that staff do not go into the room when the family members are there; is not sure what the care plan states regarding resident #3815's care; that when resident #3815 is sleeping during the night or during the day, staff #114 does not wake the resident; does not reposition the resident and does not check the restraint. On August 28, 2014 staff #105, told Inspector #580 that they would not reposition the resident when sleeping, and that "I'm bad for that". Staff #114 stated "we are all bad for that (not repositioning the resident when they are sleeping)." On September 3, 2014 Inspector #580 reviewed resident #3815's Restraint Record of August 2014 which had no resident response assessment on August 26, 204 from 0800 to 1200 although it is documented that the resident was checked for safety and repositioned. On several days throughout the RQI, Inspector #580 observed that no staff entered the room while a family member was present to check or reposition the resident, but the Restraint Record had documentation of hourly checking, repositioning, resident response assessment but not documentation of the removal or re-application of the device, even though the family member had removed the restraint.

The licensee has failed to ensure that the resident #3815 is released from the physical device and repositioned at least once every two hours. [s. 110. (2) 4.]

3. On September 3, 2014 Inspector #580 reviewed resident #3815's plan of care reviewed August 28, 2014 which indicates the use of two ½ rails, padded, whenever the resident is in bed under the focus of physical restraints, but there is no restraint order, restraint consent, Restraint Record, or restraint assessment done for the use of bed rails with padding. Throughout the course of the inspection, Inspector #580 observed the padded two 1/2 rails in the up position, while resident #3815 was in the bed.

The licensee has failed to ensure that every use of a physical device to restrain

resident #3815 under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: The person who made the order, what device was ordered, and any instructions relating to the order. [s. 110. (7) 3.]

***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 staff release a resident, specifically related to resident #3815, from the physical device and reposition at least once every two hours and, that a resident is monitored while restrained at least every hour by a member of the registered nursing staff, or by another member of the staff as authorized by the registered nursing staff and, that the documentation includes the person who made the order, what device was ordered, and any instructions relating to the order, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

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**Findings/Faits saillants :**

1. Inspector #593 did a review of resident #3833's fluid intake charts and found that from the 1st through to the 7th of August, resident #3833's fluid intake was below the home's fluid intake target of 1.5L daily. A review of Resident #3833's progress notes September 03, 2014 found that there were eight entries over the past three months indicating poor hydration status of this Resident.

The home's Food and Fluid Intake Monitoring Policy dated November 2013 states that if a Resident does not consume minimum fluid target levels for three consecutive days a dehydration assessment must take place. The results of the dehydration assessment must be documented.

Resident #3833 did not meet minimum fluid targets for seven consecutive days however a review of the Resident's care records found no completed hydration assessment. The last entry from the homes Registered Dietitian for Resident #3833 dated in August 2014, has no mention of fluid status or of a completed dehydration assessment.
During an interview with Inspector #593 September 03, 2014 staff #112 advised that if they notice a resident is drinking less or has not voided indicating poor hydration status they are required to make a referral to the Dietitian for a hydration assessment.
During an interview with Inspector #593 September 03, 2014 the homes Administrator advised that a hydration assessment should have been undertaken and that this is stated in the home's policy.
As such, a hydration assessment has not been undertaken for resident #3833 as indicated by the homes food and fluid intake monitoring policy and therefore the home has failed to comply their policy as required by the Act and Regulations. [s. 8. (1) (a),s. 8. (1) (b)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).**

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**Findings/Faits saillants :**

1. Inspector #579 did a record review of the care plan for resident #3865 that states the resident likes to go to mass every second weekend.
The current monthly recreation calendar for the home does not have spiritual events on the weekends.
Inspector #579 interviewed staff #101 who reported that there are no religious/spiritual events offered on the weekends.
The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's cultural, spiritual, and religious preferences and age-related needs and preferences. [s. 26. (3) 22.]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

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

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

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**Findings/Faits saillants :**

1. On September 3, 2014 Inspector #580 reviewed resident #3815's care plan last reviewed in 2014 which includes the restraint interventions including checking and evaluating hourly for safety, repositioning, evaluating and documenting every two hours. The Home's Physical Restraints policy RESI-10-01-01 dated November 2012 and the Physical Restraint Monitoring policy RESI-10-01-04 dated November 2012 state the minimum frequency for release and repositioning is every two hours. The care plan does not mention release of the 2 types of restraints. On September 3, 2014 Inspector #580 reviewed resident #3815's Restraint Record for a month in 2014 which included both the records for the 2 types of restraints on the same page. The Home's Physical Restraint Monitoring policy RESI-10-01-04 dated November 2012, indicates that registered staff are to transcribe the physical restraint order to the Restraint Record, utilizing one restraint record for each physical restraint. On September 3, 2014 Inspector #580 reviewed resident #3815's Medication Review dated June 13, 2014 which does not include the reason for one of the restraints. The Physical Restraints policy RESI-10-01-01 dated November 2012 indicates that an order for restraint use will include the reason for the restraint. On September 3, 2014 Inspector #580 reviewed resident #3815's "Consent to the Use of Restraints" which did not include the time the restraint will be used as per the Physical Restraints policy RESI-10-01-01 dated November 2012, Appendix I, Consent for the Use of Restraints form.

The licensee has failed to ensure that that the Home's Physical Restraints and Physical Restraint Monitoring policies are complied with. [s. 29. (1) (b)]

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

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**Findings/Faits saillants :**

1. Inspector #579 did a record review of the Recreation Program:
The Resident Recreation Program was last updated in 2011 (exact date not documented). The table of contents reflect this date of update as 2011 while most of the policies/procedures contained in the program are dated August 2005. The Program is an Extendicare Corporate program with the intention of the home adjusting to their residents needs and requests.
There is a program example of calendar events from the Kingston Extendicare that depicts bible study twice on Sundays but this Kapuskasing Extendicare home does not provide for this on their calendar of events for the residents. There are no spiritual events listed for the weekends.

The licensee has failed to ensure that the licensee of the home ensures for each organized program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes its:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 30. (1) 1.]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

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

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. On September 4, 2014 staff #119, who is in charge of scheduling and staff replacement, showed Inspector #580 the staff replacement instructions for registered staff and unregulated direct care staff (PSWs) which did not include an evaluation or annual updating.

The licensee failed to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 66. Designated lead**

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

**s. 66. (2) The designated lead must have,**
**(a) a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; and O. Reg. 79/10, s. 66 (2).**
**(b) at least one year of experience in a health care setting. O. Reg. 79/10, s. 66 (2).**

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**Findings/Faits saillants :**

1. Inspector #579 interviewed staff #101 who reported to the inspector that they are the lead for Recreation and Activity Programming and became this lead in 2013. Currently staff #101 is enrolled in a course that will give knowledge on the "Recreation Therapy Process". This is yet to be completed but is a certificate course.
Staff #101 produced certificates for several courses however does not have any diploma or degree courses in the related field required.

The licensee has failed to ensure that the designated lead for the recreational and social activities program has:
(a) A post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; and
(b) at least one year of experience in a health care setting. [s. 66. (2)]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

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

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. On August 28, 2014 Inspector #580 found the following expired items in the Home's medication storage room: Vitarub (analgesic rub), expiring June 2014; Lice Shield, expiring May 2012; and three Calomine lotions expiring December 2013. Staff #106 and staff #110 stated that the Home checks for expired medication and must not have seen these expired medications. The Home's Expiry and Dating of Medication Policy 5 -1 states that the Home is to "remove any expired medications from stock".
On August 28, 2014 Inspector #580 found the following non-resident labeled items on the medication cart: Zinc Oxide x 2 and Vitarub x 1. Staff #110 stated they apply these creams to different residents. The Home's Medication Storage Policy 3-4 which states that the following are part of the Home's drug list: Analgesic Rub, Calamine lotion and Zinc Oxide.

The licensee has failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs. [s. 129. (1) (a)]

**Issued on this 5th day of November, 2014**

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