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
Dec 14, 2015	2015_282543_0026	029578-15	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

TIFFANY BOUCHER (543), SYLVIE BYRNES (627), VALA MONESTIME BELTER (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): November 23-27, 30 and December 1-3, 2015

Two Critical Incidents were also inspected during this inspection: #000446-15 and #005418-15.

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, conducted resident and family interviews, directly observed dining and meal delivery service, observed fluid and nourishment passes, directly observed medication passes, reviewed resident health care records, reviewed staffing patterns for RNs and RPNs and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Staff (Registered Nurses and Registered Practical Nurses), Personal Support Workers (PSW), Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator, Housekeeping Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

A review of the home's Registered Nurses schedule from September 4, 2015 to November 26, 2015 indicated that there was not always a Registered Nurse (RN) present at all times. From September 4-30, 2015, seven full (an entire shift) RN shifts were not covered (7/27=26% of the time), and nine partial (part of a shift) RN shifts were not covered (9/27= 33.3% of the time), from October 1-31, 2015, 16 full RN shifts were not covered (16/31= 51.6% of the time), and 14 partial RN shifts were not covered (14/31=45% of the time) and that from November 1-26, 2015, five full RN shifts were not covered (5/26=19% of the time), and five partial RN shifts were not covered (5/26=19% of the time).

An interview with the Administrator the scheduled shifts for Registered Nurses were discussed, and they confirmed that the schedule was accurate regarding non covered or partially covered RN shifts when an RN was not present and on duty in the home. [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 to ensure that there will be least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Falls Prevention and Management Program was complied with.

A review of the home's Falls Prevention and Management Program noted that when a resident has a fall that staff were to complete an incident report or Risk Management Report to be followed up within 24 hours of completion.

A review of resident #010's progress notes identified that in September and October 2015, this resident fell a number of times. No incident report was completed for a fall in October 2015.

A review of resident #018's progress notes identified that in September and October 2015, this resident fell a number of times. No risk management report was submitted for two falls in September and one fall in October 2015.

An interview with the Administrator confirmed that a Risk Management Report should have been completed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Continence Management Program was complied with.

A review of the home's Continence Management program noted that staff were to complete a continence assessment using a clinically appropriate assessment tool that is specifically designed in assessing continence. The assessment was to include a thorough process for review of clinical health records, an interview with the resident and feedback from care staff was to be completed with any deterioration in continence level.

A review of the assessments in Point Click Care indicated that the most recent Bladder Continence Assessment completed for resident #012 was in March 2014 (admission).

An interview with PSW #110 confirmed that resident #012's continence had been deteriorating and that the same had been reported to the registered staff but was not addressed in this resident's plan of care.

An interview with RN #109 confirmed that no further assessment had been done concerning resident #012's continence and agreed this resident's plan of care did not clearly address managing their continence. [s. 8. (1) (a)]

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 the home's Falls Prevention and Management and the Continence Management Programs are complied with, to be implemented voluntarily.

WN #3: 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 Resident Abuse- Staff to Resident policy was complied with.

A Critical Incident Report (CI) related to abuse was submitted on April 7, 2015. The CI indicated that on April 4, 2015, PSW #101 grabbed resident #013 during a transfer. PSW #102 witnessed the incident and reported it to RPN #104, RN #105 and RPN #106 the next day. On April 7, 2015, PSW #102 submitted a letter to the Administrator regarding the incident that occurred on April 4, 2015, at which point a CI was submitted to the Director.

A review of the home's Resident Abuse- Staff to Resident policy revealed that any suspected or witnessed abuse, incompetent treatment or care, or misappropriation of funds must be immediately reported to the Administrator, Director of care, or their designated (eg supervisor, department head).

Interviews with the Administrator, RPN #106 and RN #107 confirmed the home's policy was not complied with. [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 the Resident Abuse- Staff to Resident policy, specifically related to reporting incidents of abuse is complied with, to be implemented voluntarily.

WN #4: 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).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) 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. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's back-up plan for nursing that addresses situations when staff cannot come to work.

A review of the home's Staffing Plan identified that this plan did not include a back-up plan for nursing staff that addressed situations when staff cannot come to work. The plan included shortages related to personal support workers, but did not include registered nursing staff.

An interview with the Administrator revealed that the home`s back up plan that addresses situations when staff cannot come to work did not include nursing care (Registered Nurses and Registered Practical Nurses). [s. 31. (3)]

2. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including 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.

An interview on December 2, 2015, with the Administrator regarding a written record kept related to the home`s staffing plan annual evaluation revealed that the home did not have a written record of the evaluations they perform on their staffing plan. [s. 31. (4)]

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 the home's back-up plan for nursing that addresses situations when registered staff cannot come to work and that there is a written record of each annual evaluation of the staffing plan including 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, to be implemented voluntarily.

WN #5: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care set out clear directions to staff and others who provide direct care to the resident.

A review of resident #001's health care record revealed a change in this resident's continence from July 2015 to November 2015. This resident went from not requiring incontinent products to requiring them. The inspector reviewed resident #001's Bladder Continence Assessment dated August, 2015, and the care plan contradicted the assessment.

Interviews with PSW #111, PSW #112, PSW #117, and PSW #122 revealed that resident #001 did not require incontinent products during the day or evening. PSW #117 explained to the inspector that resident #001 was able to toilet independently during the daytime.

An interview with PSW #121 revealed that resident #001 was both incontinent and continent depending on the day, and that they are toileted during the day.

PSW #122 indicated resident #001's Kardex's care direction was incorrect.

A review of resident #001's plan of care revealed that resident #001 required incontinent products at all times. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

A review of resident #012's care plan revealed that this resident did not require assistance with toileting.

An interview with PSW #110 identified that resident #012's continence had been worsening. PSW #110 stated they reported this to the registered staff and confirmed that resident #012's care plan did not address their changing needs related to continence.

An interview with RN #109 revealed that resident #012's the care plan did not address the resident's increased incontinence. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record of a verbal complaint was kept in the home that included the nature of the verbal complaint, the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required. The final resolution if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

An interview with resident #009 revealed a personal belonging was lost, they indicated reporting the lost item to a PSW.

A review of this resident's progress notes indicated that resident #009 had lost a personal belonging, the PSW looked for it but it was never found.

An interview with PSW #119 indicated that when a resident reported a lost item, they will look for it and if it is not found it will be reported to a registered staff.

An interview with RPN #104 revealed that the Administrator would be made aware through report, communication book and discussion. They stated there was a form at one time but they were unsure where it is now. RPN #014 confirmed that a complaint form was not completed for resident #009's missing belonging.

An interview with the Administrator confirmed that a complaint form was not completed for resident #009's missing item. [s. 101. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program.

An observation on November 26, 2015, of RN #109's medication pass revealed that for three separate medication administration the RN did not perform hand hygiene.

The inspector observed RN #109 prepare an injection for administration to resident #015 in the home's medication room, administer the injection, returned to the nursing station and documented the administration of the medication. Prepare another injection for administration to resident #106 in the home's medication room, administer administered the injection, returned to the nursing station and documented the administration of the medication. The inspector observed RN #109 prepare a third injection for administration to resident #017, administer the injection, the RN returned to the nursing station and documented the administration of the medication. At no time did the inspector observe RN #109 perform hand hygiene while administering medication to these three residents. [s. 229. (4)]

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.