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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 21, 2016	2016_336620_0026	028552-16	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

ALAIN PLANTE (620), SYLVIE BYRNES (627)

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): October 31, 2016, to November 04, 2016

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, and programs, staff education attendance records, medication administration, and implementation of the Infection Prevention and Control Program.

The following additional logs were inspected concurrently:

a critical incident the home submitted related to an alleged incident of financial abuse,
a critical incident the home submitted related an alleged incident of staff to resident verbal abuse,
a complaint received by the Ministry of Health and Long-Term Care related to an alleged incident of resident to resident abuse, and
a critical incident the home submitted related an alleged incident of visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Nursing and Personal Care (ADMIN/DOC), Registered Dietitian (RD), Maintenance Manager, Resident Assessment Instrument (RAI) Co-ordinator, Infection Control Lead, Behavioural Services Ontario Nurse (BSO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and residents' family members.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **1 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. 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.

Inspector #627 reviewed a critical incident report (CI) that was submitted to the Director. The CI described an alleged incident of staff to resident verbal abuse; whereby, PSW #102 allegedly swore at resident #006 while providing morning care.

A review of the policy titled, "Zero Tolerance of Resident Abuse and Neglect Program-RC-02-01-01", last updated April 2016, advised that, “Extendicare has a zero tolerance for abuse,” and, “forms of abuse include, but are not limited to verbal, emotional, physical, sexual and financial. Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time."

During an interview with Inspector #627, PSW #111 stated that they were providing morning care to resident #006 along with PSW #112 and PSW #102. They stated that resident #006 had exhibited responsive behaviours towards PSW #102; PSW #102 then verbally abused resident #006. PSW #111 stated they had reported the incidence to RN #114 at the end of their shift. They confirmed that the home’s expectation was that all abuse was to be reported immediately as stated in the home’s abuse policy.

During an interview with Inspector #627, PSW #102 stated they had been assisting two other PSWs to give care to resident #006. They stated that resident #006 had exhibited responsive behaviours towards them. PSW #102 stated they then verbally abused resident #006. They indicated that this was reactive and they had apologized to the resident afterwards. PSW #102 confirmed this was abusive behaviour and that it was not tolerated by the home as the home had a zero tolerance for abuse.

During an interview with Inspector #627, the ADMIN/DOC stated that they had been made aware of the incident by RN #114 at 1400 hours. This was when PSW #111 had reported the incidence to a registered staff member. PSW #102 admitted to verbally abusing resident #006. The ADMIN/DOC confirmed that PSW #102 and #111 had not followed the home's abuse policy. [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 ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to meet privately with his or her spouse or another person in a room that assured privacy.

Inspector #627 reviewed a complaint submitted to the Director which alleged resident to resident abuse. The complainant alleged that resident #005 was being verbally abused by resident #008. The complainant felt that their concerns were not taken seriously by the home.

A review of resident #005's care plan in effect at the time of the inspection identified psychological interventions. The interventions described that resident #005 could only visit resident #008 in a common area of the home. It also advised interventions that were to be utilized if resident #005 attempted to meet privately with resident #008.

A review by Inspector #627 of the progress notes since the date of admission for resident #005 did not reveal any documentation of abuse; however, there was documentation that indicated that resident #005 wished to spend time privately with resident #008.

A certain RPN documented that resident #005 appeared sad and worried at a certain time. Under the heading of, “Action” the RPN documented that they had gone over to see what was happening and that resident #005 was upset. They indicated that they had spent time with them as a result. The RPN also documented that they told resident #005 that they were able to go anywhere with resident #008, just not in their room.

Inspector #627 conducted a telephone interview with the complainant who stated that they no longer had any concerns. The complainant stated that resident #005 had been friends with resident #008 prior to their admission at the home. The complainant could not identify any time when they had witnessed resident #008 being verbally or physically abusive to resident #005.

Inspector #627 interviewed resident #005 who stated that they had a friend living in the home and identified resident #008 as their friend. Resident #005 stated that resident #008 had never yelled or hit them, that they were good to them.

During an interview with PSW #102, they stated that when resident #008 became a resident in the home, resident #005 and resident #008 would spend time together in resident #005's room talking and enjoying each other's company. PSW #102 noted that the complainant became concerned that this was not a healthy relationship for resident #005 and wanted the home to intercede. PSW #102 stated that resident #005 and #008 were allowed to spend time together in common areas but not in their room privately.

Inspector #627 interviewed the ADMIN/DOC who stated that when resident #005’s friend, resident #008, was admitted to the home the complainant wanted the home to separate resident #005 and resident #008. The ADMIN/DOC further stated that no interventions were put in place to allow resident #005 and #008 to have private time together; although they could meet in common areas. [s. 3. (1) 21.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight changes that compromised the resident's health status.

During stage one of a resident quality inspection it was identified that resident #004 had experienced a decline in a certain activity since admission, as identified in a Minimum Data Set (MDS) assessment.

Inspector #620 conducted a review of resident #004's MDS assessments and identified that a Resident Assessment Protocol (RAP) was initiated for resident #004. The RAP indicated that resident #004 experienced a significant change in health status resulting in a significant weight loss.

Inspector #620 reviewed the resident's weights and subsequent assessments which revealed that the resident had experienced significant weight changes since admission.

Inspector #620 reviewed the home's nutrition care and hydration program titled, "Dietary Services, DS-04-01-03" with a review date of September, 2016. Under the heading of nutritional assessments the policy advised that, "The Registered Dietitian/Designate

completes a nutritional assessment for every resident upon admission and whenever a significant change in the residents’ health condition has nutritional implications.”

Inspector #620 interviewed the home's RD who stated that resident #004 had experienced a number of incidences of significant weight change since their admission. Inspector #620 and the RD reviewed the resident’s significant weight changes from the resident’s admission. The RD verified that resident #004 had not been assessed immediately following the recorded significant weight changes and that the assessments were occurring too long after the weight change had been identified.

The RD stated that there was currently no formal reporting process to notify them when a resident experienced a significant weight change. They stated that sometimes an email would be sent but not always. They stated that sometimes due to scheduling as many as three weeks could pass before they would see a resident following a significant weight change.

Inspector #620 interviewed the ADMIN/DOC who verified that resident #004 had not been assessed when they experienced a significant weight gain because it was a desirable change; however, the ADMIN/DOC acknowledged that an assessment should have occurred whether there was a significant weight gain or loss. The ADMIN/DOC confirmed that the home had not performed assessments for resident #004 in a timely manner following the recorded significant weight changes. They indicated that there needed to be a change in the manner in which the RD was notified of significant weight changes and when the assessments occurred. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 28th day of November, 2016

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

Original report signed by the inspector.