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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 6, 2013	2013_140158_0025	S-000324-13	Critical Incident System

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

KELLY-JEAN SCHIENBEIN (158)

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): August 29, 2013

During the course of the inspection, the inspector(s) spoke with the Charge Registered Nurse, Registered Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) conducted a walk through of the home, observed delivery of care to residents by staff, reviewed various home policies and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.
Resident # 01 was found on their bedroom floor. The resident was transferred to the hospital where it was determined that the resident sustained injury.
Staff # S-100 assessed the resident on admission and identified the resident's fall triggers, the staff's assistance for the resident's continence care and activities of daily living.
On August 29, 2013, the Inspector reviewed resident # 01 plan of care.
The plan of care identified staff assistance with toileting and continence care, however the care delivery identified on resident # 01 flow sheets contradicts the direction set out in the plan of care.
Although, the plan of care identified that the resident was at risk to fall, the plan failed to identify the resident's specific fall triggers and related interventions to prevent falls.
Although an assessment identified resident # 01 transfer assistance, this was not reflected in resident # 01 plan of care.
The plan of care did not set out clear directions to staff and others who provide direct care to resident # 01. [s. 6. (1) (c)]

2. When resident # 03 was admitted, the Morse fall scale completed by staff # S-105 identified that the resident was at low risk to fall. Staff # S-100 documented two days later that resident # 03 required assistance to walk.
Staff # S-103 assessed resident # 03 eight days post admission and identified the resident's fall triggers.
On August 29, 2013, the Inspector observed that resident # 03 was at risk to fall related to one of the fall triggers identified in staff # S-103 assessment.
Resident # 03 plan of care was reviewed by the Inspector and the plan of care did not reflect any fall risk or include fall prevention strategies. Subsequently, resident # 03 plan of care does not provide clear direction with regards to fall prevention. [s. 6. (1) (c)]

3. On August 29, 2013, the Inspector reviewed resident # 01 progress notes, which identified that resident # 01 was started on a treatment for an infection. The progress notes further identified that resident # 01 experienced nausea, vomiting, and chills post treatment. There is no indication that the physician was notified of the resident's above symptoms post treatment. Staff # S-100 confirmed that a post treatment lab test was not completed.
Furthermore, the progress notes indicated that resident # 01 displayed further

changes in their health status. An assessment of resident # 01 care needs was not found when their condition changed. [s. 6. (10) (b)]

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 plan of care for resident # 03 set out clear directions 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).
3. The type and level of assistance required relating to activities of daily living. O. Reg. 79/10, s. 24 (2).
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions. O. Reg. 79/10, s. 24 (2).
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).
8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's care plan includes, at a minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. 4. Customary routines and comfort requirements. 5. Drugs and treatments required. 8. Diet orders, including food texture, fluid consistencies and food restrictions.
The Inspector reviewed the home's policy regarding care planning when a resident is admitted. The home's policy, " Resi - 03-01-04- care assessment and planning" states "upon admission to the home, Registered staff will complete the following by 24 hours after (resident) arrival"; the "admission Care Plan".
On August 29, 2013, the Inspector reviewed resident # 03 health care record. It was documented on resident # 03 admission check list that the admission plan of care was not completed. It was further noted by the Inspector that the date of resident # 03 plan of care was documented as being initiated four days after the resident was admitted and not within the 24 hour requirement. [s. 24. (1)]

2. On August 29, 2013, the Inspector reviewed resident # 01 health care record. An admission check list was not found however it was noted by the Inspector that the date of resident # 01 plan of care was documented as being initiated four days after the resident was admitted and not within the 24 hour requirement. Staff # S-100 indicated that the resident's assessments are completed and that direction of care delivery is identified on the "tick sheet". The "tick sheet" for resident # 01 did not include clear direction for care delivery or the resident's assessed needs. The 24 hour admission care plan was not developed for resident # 01. [s. 24. (1)]

3. The Inspector reviewed resident # 02 health care record on August 29, 2013. A complete 24-hr plan of care for resident # 02 was not found. Staff # S-100 identified that an assessment of resident # 02 as well as a "tick sheet" were completed. Staff # S-100 identified that the "tick sheet" and verbal instruction is used to direct front line staff with resident # 02 care. Although, there was a "tick sheet" in the PSW care plan binder, it identified options of care provision with no specific direction outlined. Risks and behaviours were also not identified on the "tick sheet".
The Inspector noted that it was identified in resident # 02 progress notes that the resident, who has cognitive impairment eloped. It was also noted that the resident was at risk to fall. The resident's family member also identified to the Inspector and staff # S-102 that the resident had vision problems.
It was noted on August 29, 2013, that staff # S-102 initiated resident # 02 plan of care on the computer. This plan of care, however, did not identify the above risks nor was a

copy of this computerized plan of care made available to the front line staff, who do not have access to the computer. Furthermore, staff # S-104 did not identify the above risks or fall triggers when questioned by the Inspector.
The plan of care for resident # 02 did not include the resident's risks or interventions to mitigate the resident's risk to elope or fall, the resident's customary routines and comfort requirements (continence care), the resident's drugs and treatments required or the resident's diet orders, including food texture, fluid consistencies and food restrictions. [s. 24. (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 that a 24-hour admission care plan is developed for each resident and is communicated to direct staff within the 24 hours of the resident's admission to the home, 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:

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. Resident # 01 was found on their bedroom floor. The resident was transferred to the hospital where it was determined that the resident sustained injury.
The resident's condition and circumstances, that included the recent physician ordered medication and the resident experiencing symptoms of nausea, vomiting and chills for five days warranted, a post-fall assessment.
Although, a post falls assessment was conducted, it did not consider these conditions/circumstances. [s. 49. (2)]

Issued on this 9th day of September, 2013

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