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
May 2, 2014	2014_332575_0005	S-000156-14	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

LINDSAY DYRDA (575)

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): April 23, 24, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Staff, and Personal Support Workers (PSW).

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

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. Inspector #575 reviewed the health care record for resident #001 who was admitted to the home, then was subsequently discharged to the hospital. The inspector noted in the health care record that approximately a month and a half prior to admission, resident #001 was assessed by Community Care Access Centre (CCAC) as exhibiting easily altered behaviours and no noted aggressive behaviour for the last 4 months.

The inspector reviewed the progress notes for resident #001 from the time of admission to discharge. During this time, resident #001 began exhibiting some behaviours and was being monitored by the home. A few days after admission, progress notes indicate that resident #001 was found in resident #002's room exhibiting inappropriate behaviours. When staff approached, resident #001 began to exhibit aggressive behaviours. Later that morning, resident #001 was reported as verbally abusive during morning care and not long after that, resident #001 was sent to the local emergency department for admission.

According to the Critical Incident Report, the physician spoke with the local hospital emergency physician on call to admit resident #001 to hospital for assessment. On April 24, 2014 the inspector interviewed the Administrator about the events surrounding the admission and discharge of resident #001. The Administrator stated the home was unable to control resident #001's behaviours. Subsequently, resident #001 was discharged and admitted to the local hospital as per physician's orders and the Administrators request.

On April 24, 2014 the Administrator reported to the inspector that alternatives to discharge were not considered prior to discharge and specifically a 60 day leave of absence for a psychiatric assessment was not considered. The Administrator stated resident #001's substitute decision maker was contacted by telephone to advise of the discharge, however a written notice with a detailed explanation justifying the discharge was not provided.

Before discharging resident #001 under O.Reg.79/10, s. 145(1), the licensee did not ensure that alternatives, specifically related to a psychiatric leave of absence of 60 days was considered and, where appropriate, tried. Additionally, the licensee did not ensure that a written notice was provided to the resident and the resident's substitute decision maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. [s. 148. (2)]

Issued on this 2nd day of May, 2014

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

Lindsay Dyrda