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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2017	2017_638609_0024	024235-17	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

CHAD CAMPS (609), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 20-23, 2017.

Additional logs inspected during this RQI included:

Two critical incidents submitted to the Director by the home related to resident falls;

One critical incident submitted to the Director by the home related to resident to resident abuse; and

One critical incident submitted to the Director by the home related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, residents and family of residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigations and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

7 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #642 reviewed a Critical Incident (CI) report which the home had submitted to the Director. The CI report outlined how on a particular day, resident #009 fell, was taken to hospital and diagnosed with an injury.

A review of resident #009's plan of care at the time of the fall directed staff to perform an identified intervention when the resident's risk for a specified safety concern was increased.

A review of resident #007 and #021's plans of care also found the same direction to staff to perform the identified intervention when the specified safety concern was increased.

During interviews with PSW #111 and PSW #112, both were asked if they could explain when the identified intervention was to be performed for when the specified safety concern was increased. PSW #111 and #112 described different instances to the Inspector of when a resident's specified safety concern was increased, including nighttime, morning as well as when various responsive behaviours by the resident were being demonstrated.

During an interview with RPN #113 they were asked if they could explain when the identified intervention was to be performed for when the specified safety concern was increased. The RPN stated that residents who were at increased risk from the specified

safety concern would have a specific symbol on their mobility aid. RPN #113 acknowledged that resident #009's plan of care direction did not provide clear direction to staff as to when the identified intervention was to be performed.

During an interview with RN #104 they were asked to explain when the identified intervention was to be performed for when the specified safety concern was increased. RN #104 reviewed resident #009's plan of care and stated that it did not specifically describe when the identified intervention was to be performed.

A review of the home's policy titled, "Care Planning- RC-05-01-01" last updated April 2017 which indicated that the resident's plan of care, which included the care plan, served as a communication tool which identified immediate risks to safety and care needs to allow the care team to implement strategies to mitigate risk and provide appropriate care.

During an interview with the Administrator/DOC they stated that the identified intervention to be performed when the specified safety concern was increased found in resident #007, #009 and #021's plans of care were not clear direction and should have described specifically when the resident was at an increased specified safety concern risk. [s. 6. (1) (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 plan of care sets 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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that it was complied with.

During census review and staff interviews, Inspector #609 reviewed 10 resident heights and found:

Resident #005, #010, #011, #012, #013, #014, #015, #016, or 80 per cent, had recorded heights greater than two years old; while

Resident #006, or 10 per cent, had a recorded height greater than one year old.

A review of the home's policy titled "Height and Weight Monitoring- RC-18-01-06" last updated February 2017 outlined how care staff were to take resident heights on admission and annually.

During an interview with the Administrator/DOC they verified that resident heights were to be recorded on admission as well as annually and that this did not occur. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas that were equipped with locks to restrict unsupervised access to those areas by residents, were locked when they were not being supervised by staff.

Inspector #642 observed during the initial tour of the home, the West and East linen room doors had key codes, were unlocked and unsupervised. The linen rooms contained supplies of, Tena body wash and shampoo, vita rub lotion, denture tabs, mouth wash, hand and body lotion, tooth paste, deodorant sticks and batteries charging for mechanical lifts.

During interviews with PSW #102, RPN #103 and RN #104, all verified that the two linen room doors identified were unlocked and should not have been.

During an interview with the Administrator/DOC they stated that the West and East linen room doors should always have been locked when not in use. [s. 9. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Inspector #609 reviewed a CI report that was submitted by the home to the Director, which outlined how resident #008 fell. They were subsequently admitted to the hospital with an injury.

A review of resident #008's plan of care at the time of the fall directed staff to use a specified intervention to minimize the risk of falls.

A further review of the CI report indicated that the resident's specified intervention was removed due to an increased risk of injury.

During an interview with RN #104 they stated that resident #008 was known to put themselves at increased risk from the specified intervention. The intervention was assessed as an increased risk to the resident. The RN was unable to indicate when the intervention was discontinued.

A review of the home's policy titled "Documentation Procedures- HEAL-04-02-04" last reviewed June 2004 indicated that documentation should be an indication of the resident's condition, problems, progress or lack of progress. The documentation was also to be written as events occur.

A review of the home's policy titled "Care Planning- RC-05-01-01" last updated April 2017 indicated that the resident's care plan was to be revised when appropriate to reflect the current needs based on an evaluation of the resident's response to care and treatment.

A review of resident #008's health care record found no documentation outlining in any way, the resident's increased risk from the specified intervention, nor any documentation outlining the results of the assessment to discontinue the intervention.

A further review of resident #008's plan of care found no indication that the specified intervention was removed from the plan of care.

During an interview with the Administrator/DOC they verified that resident #008's

specified intervention was discontinued related to the resident's responses to the intervention. The Administrator/DOC was unable to identify any documentation as to when the assessment to discontinue the specified intervention was conducted or when the intervention was actually removed.

The Administrator/DOC further acknowledged that resident #008's plan of care should have reflected the resident's current needs which would have resulted in the specified intervention being removed from the plan of care. [s. 30. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #642 reviewed the October 2017 Residents' Council meeting minutes and under the title "Celebration of Mass," a concern was identified that the Father responsible for Mass was not able to attend the home some of the time and that they would be looking for a replacement.

The next documentation found related to the concern was found in the Residents' Council meeting minutes dated November 2017 which indicated that Mass dates were changed to Fridays and that the Father had a replacement available.

A review of the home's policy titled "Residents' Council- RC-02-01-07" last updated April 2017 indicated that the Administrator/Designate was to respond in writing within 10 days of receiving a concern or a suggestion from the Residents' Council.

During interviews with resident #005 and resident #022 (both Residents' Council members), neither could recall the Administrator/DOC providing the Residents' Council with any written response within 10 days after the concern about Mass was brought forward by the council. Resident #005 and resident #022 could not recall receiving any written response within 10 days from the Administrator/DOC to any previous Residents' Council concerns.

During an interview with the Administrator/DOC they stated that they did not have any written documentation of their response to the Residents' Council about the concern brought forward about Mass and that they usually speak to the Residents' Council to address concerns when brought forward. [s. 57. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Inspector #609 reviewed the May 2017 Family Council meeting minutes and found that concerns were brought forward to the home related to resident room and bathroom floor cleanliness. A further review of the June and October 2017 meeting minutes found no written response from the home related to the cleanliness concerns brought forward by the Family Council.

During an interview with Family Council member #018 they could not recall receiving any written response from the home related to the cleanliness concerns brought forward in May 2017, nor could they recall a written response from the home to any concerns brought forward in the past.

During an interview with Family Council member #017 they described how they would invite the Administrator to the Family Council meetings when they had concerns to bring forward. The Family Council member would then record the Administrator's responses at that time into the meeting minutes. They could not recall ever receiving written responses from the home within 10 days or any other time frame addressing concerns brought forward by Family Council.

A review of the home's policy titled "Family Council- RC-02-01-08" last updated April 2017 indicated that the Administrator/Designate was required to respond in writing within 10 days of receiving a concern or suggestion from the Family Council.

The Administrator/DOC was asked to provide documentation to support that that home provided written responses within 10 days to concerns brought forward by Family Council. The Administrator/DOC failed to provide the requested documentation. [s. 60. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the quarterly review of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and that any changes and improvements were identified in the review.

Inspector #642 requested from the Administrator/DOC, the written record of the last quarterly review of all medication incidents, their analysis and any changes and improvements that were identified.

A review of the home's policy titled, "Medication Incident Reporting- 9-1" last updated February 2017 outlined that drug utilization trends and patterns as well as any medication incidents and adverse drug reactions were to be reviewed, any changes and improvements identified in the review were to be implemented and a written record was to be kept on file at the home.

During an interview with the Administrator/DOC they verified that quarterly medication incident reviews were conducted but that the medication incidents and adverse drug reactions record of the reviews and any changes and improvements identified were not kept as a written record and should have been. [s. 135. (2)]

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.