Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_771609_0006	024089-19, 004360-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 10, 12, 2020.

The following intake was inspected upon during this Complaint Inspection:

-One intake submitted to the Director related to allegations of improper care of a resident.

A Critical Incident System (CIS) intake related to the same allegations of improper care of a resident was completed during this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator), Office Manager, Registered Nurses (RNs), Personal Support Workers (PSWs), Dietary Manager, Cooks, and 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, training logs, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation (O. Reg.) 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director which described allegations of improper care of resident #001.

Inspector #609 reviewed resident #001's health care records and found in a progress note from the incident, that the resident was found during rounds to have been left in an improper state by staff for an extended period of time.

A review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last updated June 2019, indicated that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident was immediately reported.

During an interview with Registered Nurse (RN) #107, they described finding resident #001 in an improper state, which the resident would have been in for an extended period of time. The RN acknowledged that this should have been considered improper care and should have been reported to the Administrator.

During an interview with the Administrator, they verified that they were unaware that resident #001 was left in an improper state on a particular day and that RN #107 should have reported the incident to them or their designate.

A review of the subsequent Critical Incident (CI) report outlining the incident found it was submitted by the home months after the incident occurred. [s. 24. (1) 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 that a person who has reasonable grounds to suspect that improper or incompetent treatment of care of a resident that results in harm or a risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan.

A complaint was submitted to the Director on a particular day, which described how resident #001 was left in an improper state for a significant period of time.

Inspector #609 reviewed resident #001's health care records and found in a progress note from the incident, that the resident was found in an improper state during rounds for an expended period of time.

A review of resident #001's plan of care at the time of the incident outlined how the resident required staff assistance to correct the improper state.

A review of the Personal Support Worker (PSW) Documentation Survey Report at the time of the incident indicated that PSW #106 had provided assistance to resident #001.

During an interview with PSW #106, a review of resident #001's progress notes and Documentation Survey Report was conducted. They indicated that resident #001 required assistance to correct the improper state and that they must have forgotten the about the resident. The PSW acknowledged that they should have checked on the resident.

During an interview with RN #107, they described finding resident #001 in an improper state on a particular day and that the resident had been in that state for hours. The RN indicated that the resident should have been checked up on after staff identified the resident in an improper state.

During an interview with the Administrator, a review of resident #001's health care records were conducted. The Administrator acknowledged that care was not provided to the resident as specified in their plan when PSW #106 forgot to check on them after they identified the resident in an improper state. [s. 6. (7)]

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.