Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 5, 2023

Inspection Number: 2023-1120-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing

Lead Inspector	**Inspector Digital Signature**
Karen Hill (704609)	Karen L Hill Digitally signed by Karen L Hill Date: 2023.07.07 15:11:42 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 5-8, 2023.

The following intake(s) were inspected:
- One intake related to a fall resulting in injury.
- One intake related to a complaint regarding improper care and hot temperatures.
- One follow-up intake related to cooling requirements.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #901 from Inspection #2023-1120-0002 related to O. Reg. 246/22, s. 23.1 (1) 1. inspected by Karen Hill (704609)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

IMMEDIATE COMPLIANCE ORDER [ICO #901] Air Conditioning Requirements

NC #001 Immediate Compliance Order (ICO)
O. Reg. 246/22, s. 23.1 (1) 1., served on June 6, 2023
This ICO was complied, during this inspection.
Date Complied: June 7, 2023.

WRITTEN NOTIFICATION: Plan of Care - When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

1) The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident sustained a fall with injury, which required transfer to hospital.

The staff members identified that the resident's condition had changed significantly since their fall and that upon the resident's return from hospital, they required additional and specific care interventions.

The resident's care plan did not identify the care needs reported by the staff members. The staff members acknowledged that the care plan had not been updated to reflect the resident's care needs.

The Interim Director of Care (DOC) verified that when a resident's care needs had changed, the care plan should have been updated to reflect the resident's current care needs.

Failing to ensure that the care plan for a resident was updated, placed the resident at risk of not receiving care in accordance with their current care needs.

Sources: Observations of a resident; review of a resident's clinical record; and interviews with the DOC and other staff.

[704609]

2) The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

Rationale and Summary
A resident's care plan identified specific interventions related to bed mobility. The resident was observed without the specified interventions and with different interventions in place.

The resident's clinical record revealed that the interventions identified in the resident's care plan had been discontinued and replaced with an updated written order.

Registered staff and the DOC identified that the care plan provided direction to staff related to the resident's current care needs and that the care plan should have been updated at the time the new order was written.

There was risk to the resident when the current care needs were not revised in the resident's care plan.

Sources: Observations of resident and their room; review of resident's clinical records; and interviews with the DOC and other staff.

[704609]

WRITTEN NOTIFICATION: Plan of Care - Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

1) Specifically related to the care plan and falls prevention.

Rationale and Summary
A resident was identified at risk for falls. The care plan for the resident listed specific fall prevention interventions. Observations of the resident revealed one of the falls interventions was not in place. Staff

members confirmed that the falls intervention was not in place and should have been.

Not having falls interventions in place as per the care plan put the resident at risk for injury.

Sources: Observations of a resident and their room; a resident's clinical health record; and interviews with staff.

2) Specifically related to the care plan and personal hygiene, sleep/rest, and behaviours.

Rationale and Summary
A resident was observed without specific interventions in place. The resident's care plan identified that the specific interventions were required to be in place.

Personal support staff stated they did not review the resident's care plan; therefore, they did not implement the required interventions. The DOC identified that staff were expected to read and implement the resident's care plan.

Failing to implement the interventions as identified in the resident's care plan, placed the resident at risk of receiving improper care.

Sources: Observations of a resident; a resident's clinical health record; and interviews the DOC and other staff.

3) Specifically related to the care plan and continence care.

Rationale and Summary
A resident's care plan for continence specified that the resident was to receive specific assistance from staff at certain times.

Yet, the resident was not provided the assistance specified in their care plan.

Personal support staff acknowledged that they did not provide the assistance and registered staff verified that the resident should have received the assistance as set out in the resident's care plan.

The resident was placed at risk when the assistance identified in their care plan, was not provided by staff.

Sources: Observations of a resident; a resident's clinical health record; and interviews staff and others.

[704609]

WRITTEN NOTIFICATION: Air temperature

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (4)

The licensee has failed to ensure that air temperatures were measured and documented in required areas of the home.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care related to elevated air temperatures as well as no air conditioning in a resident's room.

Ontario Regulation 246/22 s. 24 (4) set out the requirements for licensees of Long-Term Care Homes (LTCH) to ensure that for every resident bedroom that was not served by air conditioning, the temperature was to be measured in the room once a day, in the afternoon, between 12 p.m. and 5 p.m. and documented in writing.

At the time of the inspection, air conditioning units were not installed in all resident rooms in the home. The Maintenance Lead indicated they were unable to provide documentation of the temperatures taken in the affected rooms as they did not take daily temperature readings.

Failing to ensure that on a daily basis, the temperatures were monitored for resident rooms not served by air conditioning, placed the residents at risk for heat related illnesses, as the temperatures inside and outside of where the home was located, were greater than 26 degrees Celsius on multiple days at the time of the non-compliance.

Sources: Observations of resident bedrooms; the home's temperature reading records; daily data report from Climate-Environment and Climate Change Canada; weather.gc.ca - for Kapuskasing; and interviews with the Maintenance Lead and the Interim Administrator.

[704609]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the home's falls prevention and management program was

followed, specifically where staff were required to complete a specified assessment, for a specified time.

In accordance with Ontario Regulation 246/22 s. 11 (1) (b) the licensee is required to ensure the home has in place a falls prevention and management program which includes monitoring of residents, and that it must be complied with. Specifically, staff did not comply with the licensee's monitoring protocol, which was captured in the licensee's Falls Prevention and Management program.

Rationale and Summary
The home's fall prevention program required staff to complete a specified assessment according to the home's established protocol.

A resident had sustained multiple falls. The home indicated that a specified assessment was required to be completed for a specified amount of time. For several of the fall incidents, the specified assessments were initiated but not completed according to the home's protocol.

Registered staff and the DOC acknowledged that staff were expected to complete the required assessment as outlined in the home's policy.

Failing to ensure that the specified assessment was completed as required, placed the resident at risk that a change in their condition may not have been immediately identified and treated if required.

Sources: A resident's clinical health record; a resident's fall risk management reports; the home's policy titled, "Falls Prevention and Management Program", last reviewed, March 2023; and interviews with registered staff and the DOC.

[704609]

COMPLIANCE ORDER CO #001 Plan of Care - Integration of assessments, care

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

a) Review the care plan of a resident, ensuring that the interdisciplinary team has collaborated with each

other and developed an individualized falls prevention plan for the resident, that clearly outlines and addresses their fall causes and risk factors, and reflects the resident's current condition.

Grounds
The licensee has failed to ensure that staff and others involved in the different aspects of the care of a resident, collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

Rationale and Summary
On admission, a resident was assessed by registered staff to be at risk for falls. A second admission assessment was completed by registered staff which did not identify the resident to be at risk for falls. The care plan initiated for the resident, incorrectly identified the resident's risk for falls and a referral to physiotherapy was not initiated.

After admission the resident had multiple falls, which resulted in a significant change in their condition.

Personal support staff stated at the time of the falls, the resident did not have fall prevention interventions in place while registered staff indicated that the resident was always at risk for falls. Another registered staff member identified that they usually reviewed specific information related to fall risk upon admission when developing a resident's care plan; but had not done so for the resident.

The staff members and the DOC acknowledged that the staff should have collaborated in their assessments and in the development and implementation of the resident's care plan; that the resident's care plan should have indicated that they were a fall risk and included individualized interventions.

There was a high risk identified when staff and the interdisciplinary team did not collaborate in developing and implementing a falls prevention plan for the resident, which may have contributed to the resident's significant change in condition when they fell.

Sources: Review of a resident's clinical health record; and interviews with the DOC and other staff.

[704609]

This order must be complied with by July 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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Immediate Compliance Order — Original Public Report

Report Issue Date: June 5, 2023	
Inspection Number: 2023-1120-0002	
Inspection Type: Complaint	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.06.06 15:48:32 -04'00'
Additional Inspector(s)	

INSPECTION REPORT SUMMARY

The inspection occurred on the following date(s): June 5, 2023

The following intake was inspected:

- One complaint intake related to concerns about hot temperatures.

COMPLIANCE ORDER [ICO #901] Air Conditioning Requirements

NC# 001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 23.1 (1) 1.

The Inspector is ordering the licensee to:

FLTCA, 2021, s.155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order: [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 23.1 (1) 1.

The licensee shall ensure that:

· All resident rooms have portable air conditioning units installed and operational by June 13, 2023.

Grounds

The licensee has failed to ensure that air conditioning was installed, operational and in good working order for the purpose of cooling the temperature in every resident bedroom on May 15, 2023.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care, related to elevated air temperatures as well as no air conditioning in a resident's room.

The long-term care home has 31 resident rooms. The long-term care home did not have central air conditioning other than in the hallways, dining room, kitchen, and basement.

At the time of the inspection, it was observed that the home did not have any portable or window mounted air conditioning units installed in all resident rooms.

Sources: Observations of residents' rooms; and interviews with residents, the Maintenance Lead, and the Operations Manager.

[704609]

This order must be complied with by: June 13, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order.

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP#001

Related to Compliance Order NC# 001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $25000.00, to be paid within 30 days from the date of the invoice.

In accordance with s.349 (6) (c) and (10) of O. Reg. 246/22, this administrative penalty is being issued for:

The Licensee has failed to comply with subsection 23.1 (1) of this Regulation, resulting in an order being made under section 155 of the Act. O. Reg. 246/22, s. 349 (6); O. Reg. 66/23, s. 43 (1).
Where an inspector or the Director issues a notice of administrative penalty under clause 6 (c) for the failure to comply with subsection 23.1 (1) of this Regulation, the amount of the administrative penalty is $25,000. O. Reg. 66/23, s. 43 (2).

Compliance History:

This is the first time the licensee has failed to comply with this requirement.

*Invoice with payment information will be provided under a separate mailing after service of this notice. Licensee must **NOT** pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.*

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