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
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Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: April 19, 2024

Inspection Number: 2024-1120-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Kapuskasing, Kapuskasing

Lead Inspector	**Inspector Digital Signature**
Chad Camps (609)	Chad A Camps Digitally signed by Chad A Camps Date: 2024.05.02 13:29:00 -04'00'

Additional Inspector(s)
Sylvie Byrnes (627)
Loviriza Caluza (687)

INSPECTION SUMMARY

This inspection occurred onsite on the following date(s): March 4-7, 2024.

One Proactive Compliance Inspection (PCI) intake was inspected.

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that residents' personal health information (PHI) was kept confidential in accordance with the Personal Health Information Protection Act, 2004.

Rationale and Summary

A box containing paper documents was observed at the entrance door of the home during the initial tour of the home. The paper documents contained residents' personal information (PI) and personal health information (PHI).

The Operations Manager stated that they were not aware that the identified paper documents contained PI and PHI.

Documents containing residents' PI and PHI located at the entrance of the home posed a moderate risk due to breach of residents' confidential information.

Sources: Inspector #687's observations; document/records at the entrance of the home; interview with the Operations Manager. [687]

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure that the home's equipment was kept clean and sanitary.

Rationale and Summary
Two residents were seen with dirty mobility aids.

Personal Support Worker (PSW) staff outlined how nightshift staff were expected to clean resident mobility aids weekly and as needed if they noticed the mobility aids

were dirty during the day.

On subsequent observation completed on other days, the two residents mobility aids continued to be soiled.

The Infection Prevention and Control (IPAC) lead described how staff were expected to clean mobility aids weekly and as needed and acknowledged that the residents' mobility aids were dirty.

The home's failure to ensure that the two identified residents' mobility aids were kept clean and sanitary presented low risk of harm to the residents.

Sources: Inspector #609's observations; February and March 2024 nightshift duty records; the home's policy titled "Resident Care Equipment" last reviewed November 2023; interviews with the IPAC Lead; other staff. [609]

WRITTEN NOTIFICATION: Continuous quality improvement

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 42
Continuous quality improvement
s. 42. Every licensee of a long-term care home shall implement a continuous quality improvement initiative as provided for in the regulations.

The licensee has failed to implement a Continuous Quality Improvement (CQI) initiative as provided for in the regulations.

Pursuant to O. Reg. 242/22 s. 168. (1) the licensee was to prepare a report on the CQI initiative for the home for each fiscal year no later than three months after the end of

the fiscal year.

Rationale and Summary
The home's 2023 quality meeting minutes did not include a CQI initiative report for 2022.

Both the Clinical Coordinator and the Acting Administrator stated that the home did not have a CQI initiative report for 2022.

The home's failure to implement a CQI initiative presented low risk to residents.

Sources: The home's quality meeting minutes for 2023; interviews with the Clinical Coordinator; Acting Administrator. [687]

WRITTEN NOTIFICATION: Family Council

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)
Family Council
s. 65 (7) If there is no Family Council, the licensee shall,
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

The home failed to convene semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council (FC).

Rationale and Summary
The Acting Administrator stated that no FC was established in the home since 2020. They acknowledged that there were no meetings with the residents' families and no

record of when/if the home attempted to re-establish a FC.

The home's failure to attempt reestablishment of a FC posed a missed opportunity for family members and others to be involved in the care of the residents in the home. However, at this time, it was low risk and impact to residents.

Source: Interview with the Acting Administrator. [687]

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. 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.

The licensee has failed to ensure that the doors to the home's basement and hairdressing studio were kept locked to restrict unsupervised access when they were not being supervised by staff.

Rationale and Summary
a) The Inspector observed the door leading to the home's non-residential basement area had the access code posted above the keypad. The access code had been posted for at least a month when the maintenance staff replaced the keypad.

b) The Inspector observed the hairdressing studio's door was unlocked and

unattended by staff.

The Acting Administrator verified that the code to the basement door's keypad should not have been posted and that the hairdressing studio door should have been locked.

The home's failure to ensure that the basement and hairdressing studio doors were kept locked when not attended by staff presented low risk to residents known to frequent the areas where the doors were located.

Sources: Inspector #609's observations; the home's policy titled "Security" last reviewed January 2022; interviews with the Acting Administrator; other staff. [609]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident's individualized plan to promote and manage bowel and bladder continence was implemented.

Rationale and Summary
The Inspector observed a resident in their bathroom self-transferring onto the toilet

without assistance.

The resident's toileting plan of care indicated that they needed required the assistance of staff for continence at specified times.

A PSW verified that they were assigned to the resident's care and that they did not provide any continence care to the resident that day.

The Acting Administrator verified that continence care should be provided to residents according to their plans of care.

The home's failure to ensure that the PSW implemented the resident's continence care as per the resident's plan of care presented moderate risk to the resident who required staff assistance for continence.

Sources: Inspector #609's observations; the home's policy titled "Plan of Care" last reviewed November 2023; a resident's continence plan of care; interviews with the Acting Administrator; other staff. [609]

WRITTEN NOTIFICATION: Registered dietitian

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 80 (2)
Registered dietitian
s. 80 (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

The licensee has failed to ensure that a Registered Dietitian (RD) who was a member

of the staff of the home was on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutritional care duties.

Rationale and Summary
The RD described how they performed care duties remotely.

The Acting Administrator indicated that the home had struggled to secure an RD on site, that there should be one on site.

The home's failure to ensure that a RD was present, on site for a minimum of 30 minutes per resident per month to carry out their duties presented low risk to residents as the RD was completing nutrition assessments remotely.

Sources: The "Agreement for Consulting Clinical Registered Dietitian Services"; interviews with Acting Administrator; other staff. [609]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that an interdisciplinary team met at least

quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary
The home met for three Professional Advisory Committee (PAC) meetings in 2023, where the medication administration system was evaluated. The Acting Administrator acknowledged that the home had three PAC meetings in 2023, instead of four.

There was low risk to residents when meetings to evaluate the effectiveness of the medication management system were not held quarterly.

Sources: PAC meeting minutes; interview with the Acting Administrator. [627]

COMPLIANCE ORDER CO #001 Nutritional care and hydration programs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

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

a) Ensure that PSWs complete education on the home's policies related to nutritional care, dietary services and hydration programs including but not limited to the "Meal Service and Dining Experience" policy;

b) Develop and implement an auditing process to ensure that residents are being provided with food and fluids in accordance to their therapeutic dietary requirements;

c) Ensure that the auditing process incorporates verifying that appropriate action has been taken when residents request additional food items;

d) Conduct and document the audits for four weeks or longer if continued concerns are identified and ensure that these audits include the date, time, name, and signature of the staff member(s) conducting the audits;

e) Implement corrective action if concerns are identified during the auditing process; and

f) Maintain all documentation of the audits and corrective action(s) taken and make available to the Inspector(s) upon request.

Grounds
The licensee has failed to ensure that the meal service policy related to the home's nutritional care and dietary services and hydration programs was implemented.

Specifically, the staff did not implement the home's policy titled "Meal Service and Dining Experience" last reviewed January 2022.

Rationale and Summary

a) According to two residents' therapeutic diets both required modified fluids.

The home's "Meal Service and Dining Experience" policy indicated that resident diet needs were to be accommodated.

During a meal service, the two residents were not provided with modified fluids.

The NM verified that the two residents should have been provided with modified fluids from their assigned PSWs.

The home's failure to ensure that the two residents' diets were accommodated by providing modified fluids presented moderate risk of choking to the residents.

b) During a meal service, a resident asked a PSW for more food, however, an additional serving of food was not provided to the resident.

The home's "Meal Service and Dining Experience" policy indicated that residents were to be offered second helpings of food.

The home's failure to ensure that the PSW provided the resident with more food impacted the resident's right to make their own decisions.

Sources: Inspector's observations; the home's policy titled "Meal Service and Dining Experience" last reviewed January 2022; the therapeutic diet list; residents' fluid care plans; interview with the NM. [609]

This order must be complied with by June 14, 2024

COMPLIANCE ORDER CO #002 Additional training — direct care staff

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

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

a) Complete a documented review to identify which direct care staff have not completed annual training related to continence care and bowel management and falls prevention and management;

b) Ensure all staff identified as not having completed their annual training in Part a) completes the required education. Documentation of this education must be maintained; and

c) Develop a process for ensuring that the completion of all future annual training related to continence care and falls prevention is monitored and that there is an established process for following up on any identified gaps.

Grounds

1. The home has failed to ensure that the annual Falls Prevention and management training was received by all staff who provided direct care to residents.

Rationale and Summary
Online (Surge) learning for Falls Prevention and management training in 2023 found that a portion of direct care staff did not complete the training.

The Acting Administrator stated that not all staff completed the required training in 2023.

Failure of the home to ensure that required annual training for staff members who provided direct care to residents posed a potential risk. However, the impact to residents at the time was low.

Sources: Record review of Surge learning for Falls Prevention and management in 2023; interview with the Acting Administrator; other staff. [687]

2. The licensee has failed to ensure that annual training was completed for all direct care staff related to continence care and bowel management.

Rationale and Summary
The home's 2023 continence care and bowel management annual training for direct care staff found that a portion of staff did not complete the training.

The home's failure to ensure that direct care staff completed their 2023 continence care and bowel management training presented moderate risk to residents provided care from staff who were not fully trained.

Sources: The home's 2023 continence care and bowel management training

record; interview the Acting Administrator; other staff. [609]

This order must be complied with by June 14, 2024

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.