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
Direction de l'amélioration de la performance et de la conformité

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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
Feb 14, 2014	2014_293554_0003	000076	Complaint

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 ROUGE VALLEY
551 Conlins Road, TORONTO, ON, M1B-5S1

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

KELLY BURNS (554)

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): January 24 and 29, 2014

Complaint Inspection was completed for Log #000076-14

During the course of the inspection, the inspector(s) spoke with Interim Administrator, Acting Director of Care/Assistant Director of Care (ADOC), Nurse Practitioner (NP), Nutritional Care Manager (NCM), Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Family

During the course of the inspection, the inspector(s) reviewed clinical health records, dietary referrals and or nutritional screening tools, weight records, and any elimination monitoring tool. Reviewed the home's policies relating to Continence Management Program, Weight Change Program, Registered Dietitian/Dietary Department Communication and Referral, Resident Assessment, Notification of Family, Care Planning. Reviewed Registered Staff Meeting minutes (June 2013), staff training/education records for 2013, relating to Constipation and Bowel Management, Continence Management, Referral Process-Weight Change. Reviewed Personnel Files (e.g. Administrator Credentials, coverage of DOC role) and the home's Complaint Log Binder for 2013.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Death
Sufficient Staffing

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 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Related to Log #000076 – Resident #001

The Licensee failed to ensure that there was a written plan of care for Resident #001 that set out the planned care for the resident, related to 'constipation'.

Progress notes reviewed, for the time period reviewed, identified that Resident #001, was experiencing episodes of constipation and or diarrhea. Episodes of constipation and loose bowel movements increased in frequency during during a specific three month period.

Physician's notes reviewed for Resident #001 indicated the following:
- resident having loose stools, hydration fair
- resident was having frequent bowel movements; staff to monitor

Interviews with the Registered Dietitian(RD), Nutritional Care Manager(NCM), RN Supervisor(RN)(#109), and assigned full-time Personal Support Worker(PSW)(#107) for Resident #001 all stated "they were unaware that resident was experiencing issues related to constipation or diarrhea".

RD and NCM stated "they were both not aware that Resident #001 was experiencing issues with constipation, until the day resident was transferred to hospital".

The written care plan for the period reviewed did not identify a focus of constipation or diarrhea or risks related to potential dehydration, despite issues Resident #001 was experiencing.

The care plan failed to identify interventions specific to: prevention of constipation or diarrhea, individualized toileting schedule and interventions specific to monitoring or effectiveness of bowel medications for this resident. [s. 6. (1) (c)]

2. Related to Log #000076 - Resident #001

The Licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

1) A review of progress notes and weight records, for the period reviewed, identified that Resident #001 had experienced a significant weight loss during the first four months of the year. Progress note on a specific date, written by the Registered Dietitian(RD) stated "resident's weight was below ideal body weight at that time". Resident #001 continued to lose weight until the end of the year. RD stated that

"Resident #001's weight loss was not planned".

Progress notes identify that Resident #001's physician was not notified of resident's weight loss, experienced until at later date.

No referrals or communication were forwarded to the RD or dietary department with regards to weight loss experienced by Resident #001, as indicated in interviews with RD, Nutritional Care Manager (NCM) and Registered Nurse (RN) (#109) and as demonstrated by review of resident's health record.

RD stated "no awareness of the significant weight loss until a later date"; RD further commented "that the loss in weight was identified by RD, not nursing staff, when reviewing the homes weights for the month of indicated".

Interviews with RN (#109), Registered Practical Nurse (RPN) (#108) and Assistant Director of Care (ADOC) indicated "no referral or communication as to weight loss had been sent to RD/ dietary department" for the period reviewed.

RD indicated "Food Services Manager (FSM) did not communicate weight loss concerns regarding Resident #001". RD and NCM indicated that "FSM should have identified Resident #001 as having significant and ongoing weight loss during the quarterly nutritional reviews".

RD agreed that "Resident #001 should have been re-assessed by RD and a decision made as to possible interventions to prevent further weight loss".

2) In a interview with the RD, they commented that "dietary referrals are rarely being completed by registered nursing staff". RD indicated that "this month, there were 23 residents with weight loss and no referrals submitted to RD or dietary department".

Examples:
Resident #002 - weight down 13.5kg in one month
Resident #003 - weight down 7.1kg in six months
Resident #004 - weight down 4.1kg in one month

The above resident's had no dietary referrals, referring to weight loss, on file. RD was in agreement that "Resident's #002, #003 and #004, had no referrals on file for concerns relating to weight loss".

RD and NCM, both indicated "concerns regarding registered nursing staff not completing referrals as per the home's policy, had been forward to Administrator, DOC and ADOC in the past, and most recently to the Interim Administrator and ADOC without any changes seen".

RD further stated, that "registered nursing staff were re-educated mid year as to the importance of completing dietary referrals, but no progress has been seen despite re-education".

Interviews with an RN (#109) and RPN (#108), both indicated that they were familiar with the home's policies 'Weight Change Program' and 'Registered Dietitian Communication/Referral'. Both staff stated "registered nursing staff are to complete the referral form, when a resident has weight loss". Neither registered nursing staff interviewed could account for why referrals for Resident #001 or other resident's had not been completed.

ADOC stated "was aware that referrals relating to weight loss are not being completed as per the home's policy".

3) A review of progress notes for the period reviewed, identified that Resident #001 was experiencing episodes of constipation and diarrhea. Progress notes written by registered nursing staff, indicate diarrhea became more frequent during the period reviewed. The resident has since deceased.

Interviews with the RD and NCM indicated "RD and or Dietary Department had not received any dietary referrals relating to bowel issues (constipation or diarrhea) for Resident # 001". A review of resident's chart confirmed that no referral relating to GI issues had been forwarded.

RD indicated that "Food Services Manager (FSM) should have identified that Resident #001 was experiencing constipation and or diarrhea during the quarterly nutritional review". RD indicated that "if there was an awareness of issues being experienced by Resident #001, the RD would have intervened to implement interventions to reduce incidence of constipation and or diarrhea".

RN (#109) and RPN (#108) both indicated, that "no dietary referrals had been sent by the nursing department with regards to Resident #001 having bowel related issues

(constipation or diarrhea)".

RN (#109) indicated "no awareness of Resident #001 experiencing constipation or diarrhea". RN did state "progress notes are reviewed daily as to resident status" and further commented "as the RN Supervisor, duties include going unit to unit to receive update from RPN's and to assess any residents acutely ill".

RD and NCM both stated "no awareness of Resident #001 experiencing bowel related issues". Both indicated "first time hearing of issues being experienced by Resident # 001 was the day resident was transferred to hospital". [s. 6. (4) (a)]

3. Related to Log #000076 - Resident #001

The Licensee failed to ensure that Resident #001's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Progress notes reviewed for the period reviewed, identified that Resident #001 experienced 'significant weight loss' between a specific time period. The resident continued to lose weight, throughout the remainder of the year.

Progress notes for the period reviewed indicate that Resident #001's substitute decision-maker(SDM) was not notified of the weight loss until the annual care conference.

Interviews with Registered Nurse(RN)(#109), and Registered Practical Nurse(RPN) (#108) indicated that "Registered Dietitian(RD) is responsible to notify families of resident weight loss". RD indicated "family notification was not made RD and registered nursing staff are to notify families of concerns".

An interview with Resident #001's SDM confirmed that "the licensee had not communicated the significant weight loss until the care conference". The SDM indicated "no awareness of the continued weight loss throughout the remaining calendar year".

The SDM for Resident #001, indicated that "no rationale for the resident's weight loss was offered by the licensee nor the Attending Physician". [s. 6. (5)]

4. Related to Log #000076 - Resident #001

The Licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A review of the progress notes, for the period reviewed, indicated the Attending Physician visited the home on a specific date. Notes indicate the physician examined Resident #001 and charted "complaints of abdominal fullness, discomfort" and left orders for diagnostic testing to be completed.

Progress notes for the period reviewed, state that Resident #001 continued to experience issues with abdominal fullness. Resident #001's condition deteriorated, resulting in transfer to hospital. Resident #001 died while in hospital.

Health records for Resident #001, failed to demonstrate that a referral was sent requesting need for diagnostic testing and failed to demonstrate that an ultrasound was completed as per the physician's orders.

Interview with RPN(#108), indicated that "diagnostic testing was not completed due to the holidays"; she further stated "was unsure as to why it wasn't done after the holidays".

Interview with RN(#109), indicated "didn't recall seeing order for diagnostic testing or being told by the RPN of the need for Resident #001 to have diagnostic testing completed". RN(#109) stated "might not have been done as service that comes into the home to do the testing is inconsistent in their services and we have to call them frequently to get them to come in". RN(#109) stated "all referrals are completed by RN" and indicated "no recollection of sending a fax requesting diagnostic testing for the resident".

ADOC indicated she could not find any request for an appointment date for an diagnostic test for Resident #001 and the lab had no results of diagnostic testing being completed for the resident.

Nurse Practitioner for the home, reviewed diagnostic testing performed at the hospital. [s. 6. (7)]

5. Related to Log #000076 - Resident #001

The Licensee failed to ensure that the resident is reassessed and the plan of care is reviewed and revised when the care set out in the plan of care has not been effective.

A review of progress notes and weight records for the period reviewed, identified that Resident #001 was experiencing weight loss. The resident had a significant weight loss, between a specific time period, as indicated by the weight records; weight records indicated weight loss continued until end of the year.

Registered Dietitian's note on a specific date, indicated "Resident #001 had weight loss of 6kg in 6 months, a significant loss and that resident was below ideal body weight". RD stated "resident eating well and that no nutritional interventions would be implemented". RD indicated in progress note, that "Food Services Manager(FSM) was to monitor and report any concerns to RD". RD indicated "weight loss for this resident was not planned".

Physician's notes on specific dates indicated:
- resident had weight loss and was not eating well; blood work was ordered to rule out cause of weight loss
- resident was losing weight

Progress note on a specific date indicate, "family voiced concern as to weight loss, requested Resource be given".

Interview with RD indicated "no awareness of family request for nutritional supplement".

Nutritional Screening, completed by FSM during specific quarters of the year failed to identify that Resident #001 had significant weight loss, and was having continued weight loss during this time period.

The written care plan for the period reviewed, identified that Resident #001 was a 'moderate nutritional risk' due to fair appetite and potential for weight loss; the goal of care was 'prevention of weight loss'. Interventions listed as: provide an apple at HS nourishment, regular / regular diet, encourage and assist at meals as required. No amendments, surrounding nutritional care were made to the care plan despite resident's continued weight loss being experienced. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 there was a written plan of care for all residents that sets out the planned care for the resident, related to bowel care management, including constipation; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and to ensure that a resident is reassessed and the plan of care is reviewed and revised when the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. Related to Log # 000076 - Resident # 001

Licensee failed to ensure the Continence Care and Bowel Management Program provided for treatment and interventions to prevent constipation, including nutrition and hydration protocols.

1) The home's policy, 'Continence Care Program' (#RESI-10-04-01), states "the definition for constipation and bowel management as a set of multidisciplinary directives which guide staff in
implementing appropriate interventions based on resident assessment and status. The directives often include dietary interventions (increased fibre), and medical interventions (laxative, stool softener)".

The home's policy,'Continence Care Program', makes reference to 'directives to guide staff in implementing appropriate interventions based on resident assessment and status', but no 'directives' were located nor could directives be provided by ADOC or registered nursing staff interviewed.

The home's policy, 'Continence Care Program', does not provide treatments and or interventions to prevent constipation, including nutrition and hydration protocols.

RPN (#108) and RN (#109) both described a bowel protocol used within the home, but neither staff could provide a written copy of the bowel care directives or protocols being used.

ADOC indicated that "the home does not have medical directives related to bowel protocols". ADOC was unaware of bowel protocols RPN (#108) or RN (#109) were referring too".

ADOC did indicate that "on admission to the home, all residents receive a general order for laxative - if no bowel movement after 2 days, give Milk of Magnesium 30mls".

RD and NCM indicated "the home does not have a specific policy to address constipation or bowel management" nor does the home have "specific written guidelines or protocols to prevent constipation".

The NCM indicated "no specific protocols are in place to address constipation" and further indicated that if a resident was identified as having bowel related issues e.g. constipation, that a referral would need to be initiated with the Registered Dietitian even for the use of prune juice as such is considered a therapeutic intervention.

Interim Administrator and ADOC indicated that "the home does not have a specific policy for Constipation or Bowel Management" and that the policy they have been

directed to follow is the "Continence Care Program" policy.

2) Related to Log #000076 - Resident #001

A review of the progress notes for the period reviewed, identified that Resident #001 was experiencing episodes of constipation and diarrhea. Progress notes written by registered nursing staff indicate that diarrhea became more frequent during a specified time period.

Medication Administration Records (MAR) for period reviewed, indicated that 'as needed orders' for Fleet Enema and Bisacodyl Suppository was only administered on specific date, both medications were given once.

Progress notes indicate the physician examined Resident #001 on a specific date, and charted "complaints of abdominal fullness, discomfort". Physician left orders requesting diagnostic testing to be completed.

Progress notes during a specific time period, state that Resident #001 continued to experience issues with abdominal fullness. Resident #001's condition deteriorated, resulting in the need to transfer to hospital. Resident later died while in hospital.

Nurse Practitioner for the home, reviewed diagnostic testing performed at the hospital. [s. 51. (1) 2.]

2. Related to Log #000076 - Resident #001

The Licensee failed to ensure that a resident who are incontinent receive an assessment that includes identification of causal factors, patterns or type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

1)Progress notes, for the period reviewed, identified that Resident #001 was having episodes of 'loose' bowel movements. Resident #001 has no diagnosis of any bowel problems.

The written care plan was amended at a later date, to identify 'occasional bowel

incontinence'. The goal of care was identified as maintain continence, with interventions listed as: establish evacuation pattern using bowel tool, hold laxatives and stool softeners with onset of diarrhea and for three days post resolution of diarrhea.

The care plan does not identify casual factors related to bowel incontinence, nor the potential to restore function with specific interventions such as a scheduled toileting routine for Resident #001.

Resident #001's health record failed to demonstrate that an assessment relating to bowel incontinence was conducted using a clinically appropriate assessment tools designed for assessment of resident's incontinence. Bowel incontinence was identified in the written care plan, as a 'new' area of focus at a later date.

2)The home's policy 'Continence Management Program'(RESI-10-04-01) directs that staff will complete a continence assessment using a clinically appropriate tool specifically designed for incontinence. The assessment is to be completed: on admission, with any deterioration in continence level and with changes that may affect (bladder or) bowel incontinence.

ADOC and RN (#109) indicated "no current assessment have been completed for Resident #001, relating to bowel incontinence and that assessments are only completed on admission to the home". [s. 51. (2) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 residents who are incontinent receive an assessment that includes identification of causal factors, patterns or type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Related to Log #000076

Under O.Reg. 79/10, s. 219 (1) the interval for the purpose of paragraph 6 of subsection 76 (7) of the Act, the following are annual intervals.

The Licensee failed to ensure that all direct care staff have been provided annual training in Bowel Care Management.

Interview of RN(#109), RPN(#108), and PSW(#107) indicated that they could not remember if they had received training in 2013 relating to Bowel Care Management.

ADOC did indicate staff training on 'incontinence' was conducted, but indicated training was specific to 'incontinence products and selection for use'; twenty-six staff attended.

Education was conducted on 'Referral Process for Constipation and Hydration, in which seventeen registered staff attended.

ADOC indicated "no staff training specific to Bowel Care Protocols or Management, had been conducted during the year in review" for all direct care staff. [s. 221. (1) 3.]

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 all direct care staff have been provided annual training in Continence Care and Bowel Care Management, specifically as it relates to constipation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. Related to Log #000076 - Resident #001

The Licensee failed to ensure that no order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

Progress notes, for the period reviewed, identified that Resident #001 was having episodes of constipation and loose bowel movements. Resident #001 had no diagnosis of any bowel problems.

A review of Physicians Medication Quarterly Review, for the period reviewed, for Resident #001, indicated that not all medications intended for use on 'as required' basis contained specific directions for administration by the Attending Physician, specifically:
- Bisacodyl 10mg Suppository, insert 1 suppository per rectum as needed
- Enemol Enema, insert 1 enema per rectum as needed
- Sennosides A&B 8.6mg, 1 tablet by mouth as once daily as needed

The physician's orders do not provide direction as to frequency for use of the drug, nor does it provide rationale for use/need of the drug specific to Resident #001's need or condition. [s. 117. (b)]

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Ministry of Health and Long-Term Care

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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

Issued on this 18th day of February, 2014

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

Kelly Burns (#554)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2014_293554_0003
Log No. / Registre no:	000076
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 14, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE ROUGE VALLEY 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~CAROL BALDASTI~~ Terri Pilgrim-Deane Interim Administrator

FEB. 14/14

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The plan will identify strategies:
- to provide education or re-education to all registered nursing staff as to the home's policy and procedures relating to a) Weight Change Program, b) Registered Dietitian / Dietary Department Communication and Referral, specifically as it related to weight loss and or bowel management issues e.g. Gastrointestinal (GI) problems
- to ensure that staff demonstrate their ability to competently and consistently follow the polices of the home

The plan must be submitted by email to: kelly.burns@ontario.ca or fax to the Attention of Kelly Burns, MOHLTC Nursing Inspector at (705) 755-4516. The plan must be submitted on or before February 21, 2014

Grounds / Motifs :

1. Related to Log # 000076 - Resident #001

The Licensee failed to ensure that the staff and others involved in the different

aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

1) A review of progress notes and weight records, for the period reviewed, identified that Resident #001 was experienced a significant weight loss during the first four months of the year. Progress notes on a specific date, written by the Registered Dietitian(RD) stated "resident's weight was below ideal body weight at that time". Resident #001 continued to lose weight until the end of the year. RD stated that "Resident # 001's weight loss was not planned".

Progress notes identify that Resident # 001's physician was not notified of resident's weight loss, experienced until a later date.

No referrals or communication were forwarded to the RD or dietary department with regards to weight loss experienced by Resident #001, as indicated in interviews with RD, Nutritional Care Manager (NCM) and Registered Nurse (RN) (#109) and as demonstrated by review of resident's health record.

RD stated "no awareness of the significant weight loss until a later date"; RD further commented "that the loss in weight was identified by RD, not nursing staff, when reviewing the homes weights for the month indicated".

Interviews with RN (#109), Registered Practical Nurse (RPN) (#108) and Assistant Director of Care (ADOC) indicated "no referral or communication as to weight loss had been sent to RD/ dietary department" for the period reviewed.

RD indicated "Food Services Manager (FSM) did not communicate weight loss concerns regarding Resident # 001". RD and NCM indicated that "FSM should have identified Resident #001 as having significant and ongoing weight loss during the quarterly nutritional reviews".

RD agreed that "Resident # 001 should have been re-assessed by RD and a decision made as to possible interventions to prevent further weight loss".

2) In a interview with the RD, they commented that "dietary referrals are rarely being completed by registered nursing staff". RD indicated that "this month, there were 23 residents with weight loss and no referrals submitted to RD or dietary department".

Examples:
Resident #002 - weight down 13.5kg in one month
Resident #003 - weight down 7.1kg in six months
Resident #004 - weight down 4.1kg in one month

The above resident's had no dietary referrals, referring to weight loss, on file. RD was in agreement that "Resident's #002, #003 and #004, had no referrals on file for concerns relating to weight loss".

RD and NCM, both indicated "concerns regarding registered nursing staff not completing referrals as per the home's policy, had been forward to Administrator, DOC and ADOC in the past, and most recently to the Interim Administrator and ADOC without any changes seen".

RD further stated, that "registered nursing staff were re-educated mid year as to the importance of completing dietary referrals, but no progress has been seen despite re-education".

Interviews with an RN (#109) and RPN (#108), both indicated that they were familiar with the home's policies 'Weight Change Program' and 'Registered Dietitian Communication/Referral'. Both staff stated "registered nursing staff are to complete the referral form, when a resident has weight loss". Neither registered nursing staff interviewed could account for why referrals for Resident #001 or other resident's had not been completed.

ADOC stated "was aware that referrals relating to weight loss are not being completed as per the home's policy".

3) A review of progress notes for the period reviewed, identified that Resident # 001 was experiencing episodes of constipation and diarrhea. Progress notes written by registered nursing staff, indicate diarrhea became more frequent during the period reviewed. The resident has since deceased.

Interviews with the RD and NCM indicated "RD and or Dietary Department had not received any dietary referrals relating to bowel issues (constipation or diarrhea) for Resident # 001". A review of resident's chart confirmed that no referral relating to GI issues had been forwarded.

RD indicated that "Food Services Manager (FSM) should have identified that Resident #001 was experiencing constipation and or diarrhea during the quarterly nutritional review". RD indicated that "if there was an awareness of issues being experienced by Resident #001, the RD would have intervened to implement interventions to reduce incidence of constipation and or diarrhea".

RN (#109) and RPN (#108) both indicated, that "no dietary referrals had been sent by the nursing department with regards to Resident # 001 having bowel related issues (constipation or diarrhea)".

RN (#109) indicated "no awareness of Resident #001 experiencing constipation or diarrhea". RN did state "progress notes are reviewed daily as to resident status" and further commented "as the RN Supervisor, duties include going unit to unit to receive update from RPN's and to assess any residents acutely ill".

RD and NCM both stated "no awareness of Resident #001 experiencing bowel related issues". Both indicated "first time hearing of issues being experienced by Resident # 001 was the day resident was transferred to hospital".
(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 07, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:

1. Treatments and interventions to promote continence.
2. Treatments and interventions to prevent constipation, including nutrition and hydration protocols.
3. Toileting programs, including protocols for bowel management.
4. Strategies to maximize residents' independence, comfort and dignity, including equipment, supplies, devices and assistive aids.
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

Order / Ordre :

The Licensee shall prepare, submit and implement a plan to ensure that the Continence Care and Bowel Management Program, at minimum provides for treatments and interventions to prevent constipation, including nutrition and hydration protocols.

The plan will identify strategies:
- to review and revise the home's policy 'Continence Care Program', ensuring the program identifies and includes interventions and treatments to prevent constipation,
including nutrition and hydration
- to education and or the re-education of all registered nursing staff as to procedures relating to Bowel Care Management and Constipation, with an emphasis on abdominal assessment, interventions to prevent constipation, monitoring effectiveness of bowel related medications, and steps to be taken when a resident is experiencing continued bowel related issues (constipation or diarrhea) regardless of the intervention
- to provide education or re-education of all direct care staff as to bowel care management and risks associated with constipation and or diarrhea
- to ensure that staff demonstrate their ability to competently and consistently follow the policies and procedures of the home

The plan must be submitted in writing and sent by email to: kelly.burns@ontario.ca or by fax to: Attention Kelly Burns, MOHLTC Nursing Inspector at (705) 755-4516. The compliance plan must be received on or before February 21, 2014.

Grounds / Motifs :

1. Related to Log # 000076 - Resident # 001

Licensee failed to ensure the Continence Care and Bowel Management Program provided for treatment and interventions to prevent constipation, including nutrition and hydration protocols.

1) The home's policy, 'Continence Care Program' (#RESI-10-04-01), states "the definition for constipation and bowel management as a set of multidisciplinary directives which guide staff in implementing appropriate interventions based on resident assessment and status. The directives often include dietary interventions (increased fibre), and medical interventions (laxative, stool softener)".

The home's policy, 'Continence Care Program', makes reference to 'directives to guide staff in implementing appropriate interventions based on resident assessment and status', but no 'directives' were located nor could directives be provided by ADOC or registered nursing staff interviewed.

The home's policy, 'Continence Care Program', does not provide treatments and or interventions to prevent constipation, including nutrition and hydration protocols.

RPN (#108) and RN (#109) both described a bowel protocol used within the home, but neither staff could provide a written copy of the bowel care directives or protocols being used.

ADOC indicated that "the home does not have medical directives related to bowel protocols". ADOC was unaware of bowel protocols RPN (#108) or RN (#109) were referring too".

ADOC did indicate that "on admission to the home, all residents receive a general order for laxative - if no bowel movement after 2 days, give Milk of Magnesium 30mls".

RD and NCM indicated "the home does not have a specific policy to address constipation or bowel management" nor does the home have "specific written guidelines or protocols to prevent constipation".

The NCM indicated "no specific protocols are in place to address constipation" and further indicated that if a resident was identified as having bowel related issues e.g. constipation, that a referral would need to be initiated with the Registered Dietitian even for the use of prune juice as such is considered a therapeutic intervention.

Interim Administrator and ADOC indicated that "the home does not have a specific policy for Constipation or Bowel Management" and that the policy they have been directed to follow is the "Continence Care Program" policy.

2) Related to Log #000076 - Resident #001

A review of the progress notes for the period reviewed, identified that Resident

#001 was experiencing episodes of constipation and diarrhea. Progress notes written by registered nursing staff indicate that diarrhea became more frequent during a specified time period.

Medication Administration Records (MAR) for the period reviewed, indicated that 'as needed orders' for Fleet Enema and Bisacodyl Suppository was only administered on specific date, both medications were given once.

Progress notes indicate the physician examined Resident #001 on a specific date, and charted "complaints of abdominal fullness, discomfort". Physician left orders requesting diagnostic testing to be completed.

Progress notes during a specific time period, state that Resident #001 continued to experience issues with abdominal fullness. Resident #001's condition deteriorated, resulting in the need to transfer to hospital. Resident later died while in hospital.

Nurse Practitioner for the home, reviewed diagnostic testing performed at the hospital.
(554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 14, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of February, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kelly Burns

Service Area Office / Bureau régional de services : Ottawa Service Area Office