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

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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
Oct 6, 2014	2014_198117_0025	O-000855-14	Resident Quality Inspection

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE WEST END VILLA
2179 ELMIRA DRIVE, OTTAWA, ON, K2C-3S1

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

LYNE DUCHESNE (117), LISA KLUKE (547), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 22, 23, 24, 25, 26, 29, 30 & October 1 and 2, 2014

It is noted that the following inspections were conducted during and are included in this Resident Quality Inspection:
1) Follow Up Inspection to Compliance Orders LTCHA s. 6 (1)
2) Follow Up Inspection to Compliance Orders O.Reg. 79/10 s. 36
3) Complaint Inspections Logs #O-000771-14 and #O-000775-14
4) Critical Incident Inspections Logs #O-000407-14, #O-000449-14, #O-000503-14, #O-000524-14, #O-000555-14, #O-000586-14, #O-000628-14, #O-000637-14,

#O-000651-14, #O-000930-14 and #O-000995-14.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Assistant Director of Care, Support Services Manager, Dietary Services Manager, Registered Dietitian (RD), RAI Coordinator, Activity Programs Manager, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several residents, several resident family members and caregivers, the President of the Resident Council and the Vice Chair of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents health care record; reviewed Behavioural Support Ontario (BSO) mapping documentation; observed resident care and services; examined resident rooms, care areas and common areas; observed the lunch time meal services of September 22 and 30, 2014; observed several morning beverage collation passes and afternoon collation passes; examined resident care equipment and resident to staff communication and repsonse system; reviewed the home's maintenance logs; reviewed the home's Medication Administration Processes, Infection Control Program, Skin and Wound Care Program, Responsive Behaviours Program, Falls Management Programs; reviewed the Resident and Family Council Meeting Minutes for 2013 and 2014; reviewed the registered nursing and PSW staffing schedules for the weeks of September 22 and 29 2014; reviewed the following policies : Prevention of Resident Abuse - Staff to Resident #OPER-02-02-04 dated November 2013, Resident Abuse by Persons other then Staff #OPER-02-02-04 dated November 2013, Preventative Skin Care # 03-03, dated June 2010, Pressure Ulcers # 03-07, dated June 2010, Skin Treatments # 03-05, dated June 2010, Remedial Maintenance Program #MNTC-01 -01-03; and reviewed several critical incident reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident equipment is kept clean and

sanitary.

On September 22, 2014, Inspector #549 noted for Resident #4 that the resident's walker had dried food debris on the seat and handles. On September 25, 2014 Inspector #547 also observed this resident's walker to have food debris on the seat, rails, and on all four wheels.

On September 24, 2014, Inspector #117 noted Resident #12's wheelchair seat cushion to be heavily soiled with stains as well as along the top of the resident's back cushion. On September 25th and 26th, 2014 Inspector #547 also noted Resident #12's wheelchair seat cushion to be heavily soiled with stains, food debris and dried white matter remains stuck along the top of the resident's back cushion.

On September 26, 2014, Inspector #547 interviewed staff member S#110 noted that Resident #12's seat and back cushions were stained and soiled. Staff member S #118 also noted that Resident #4's walker was heavily soiled, and required wipe down to remove the dried food debris. Both staff members S #110 and S#118 indicated that if they note a resident's equipment to be soiled, that they will wipe it down and clean them as required for the residents. Both staff indicated that the deep cleaning of resident equipment is done by night shift staff.

Upon record review on September 25, 2014 of the night work book on the second floor the night routine indicated a wheelchair cleaning assignments is designated to every night shift. This assignment sheets indicates a Wheelchair/Walker cleaning schedule. It was noted that five residents equipment was not initialed to date this month. Resident #4's walker was initialed for September 23, 2014 however the walker was first noted to be soiled after breakfast on September 23, 2014. Resident #12 was initialed to have been cleaned on September 3rd, 2014. The bottom of this document indicates that it needs to be sent to the DOC at the end of each month. [s. 15. (2) (a)]

2. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good stated of repair.

On September 25, 2014, it was noted on the 5th floor that the resident to staff communication call system bell light outside the resident's room #511 was not functional. Both call bell cords did not initiate any light outside the resident's room. It was noted that the room number did appear on the main screen by the nursing station, and only an initial bell rang. The home is also set up with a central hallway

light to notify staff in any hallway for the floor that a resident's call bell is ringing also with an audible alarm. The 5th floor central hallway lights were also not lit in the north, south or west hallways when inspector #547 activated room # 511 call system bell. It was further noted, that room #525 did light outside the room with an initial ring tone, but it did not appear on the screen at the nursing station.

On September 26, 2014, Inspector #547 conducted an interview with staff member S #120 who indicated that the bells do not ring audibly on the 5th floor, that they look at the screens and down the hallway to look for room lights to know if someone is asking for help as she indicated that this floor often has trouble with the call bell system, as no audible ringers which is different than the other floors in the home.

Interviews with staff members S#106 and S#120 were also conducted on this same date where both staff members indicated they were aware of the malfunctioning call bell system on the floor, and that it has been a while since there has been no audible alarms that ring to remind staff of a call from a resident. Both staff members indicated that they would look down the hallway to see if any lights lit, or if the room number is noted on the electronic screen at the nursing station. Both staff members showed Inspector #547 the maintenance communication book that did not have any record of malfunctioning call bells on the floor. Inspector #547 reviewed the 5th floor 24 hour report book and no indication of any issues with the call bells were noted from the 25th September, 2014.

Upon review of the Maintenance log book for the 5th floor, it was noted that on the 7th September, 2014, regarding room # 511-bed 1 and 2 that call bell doesn't work. This resident hallway light is still burnt out despite it being fixed on September 8th, 2014. Support Services staff member S#103 indicated that the electrical company who evaluated the call light issue for room #511 indicated that the wrong bulb was placed in the outlet, as it is supposed to be a 70 watt bulb, and not a 35 watt buld which caused the light to burn out quickly.

Interview with Support Services Manager on September 26, 2014, who indicated that he was not made aware of the malfunctioning call system on the 5th floor until it was brought to his attention on Wednesday the 25th of September, 2014 by Inspector #547 and that the home's expectation as per the policy and procedure, for nursing staff to communicate with Maintenance department regarding anything that needs repair and that staff on the 5th floor had not indicated any issues with the call system in the unit communication book for maintenance repairs, or any phone calls regarding

a need for repairs.

Inspector #547 interviewed the Administrator on September 27, 3014 who indicated that staff should have notified the Manager Support Services of the call bell system issue if they thought it was not functioning properly. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Residents #4 and #12 mobility equipment is kept clean and sanitary as well as that resident to staff communication call system be kept in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with specified weight changes are assessed and that actions are taken.

A) Resident #8's weight declined 6.6% (4.4kg) between November and a specified day in December, 2013. December weight of 61.8kg also represented a decline of 9.4% (6.4kg) over a three month period (September to December, 2013).

Resident #8's care plan in effect during that period of time stated that the resident was at high nutritional risk and that he/she consumed a liquefied puree diet and received supplemental Resource 2.0 60ml four times daily.

Resident #8's weight loss was assessed two months later on a specified day in February 2014 when the Registered Dietitian (RD) wrote the Resident Assessment Protocol (RAP) for Assessment Protocol #12 Nutritional Status. By this time, the resident's weight had further declined 1.9% (1.2kg) December, 2013 to January, 2014, for an overall loss of loss of 11.1% (7.6kg) over a three month period (October, 2013 to January, 2014).

Resident #8's weight declined 10.1% (6.9kg) from September, 2013 to March 10, 2014 (a six month period). This weight change was not assessed by the RD.

B) Resident #9 experienced weight loss of 4.9% (3.8kg) April to May, 2014. May weight of 73.8kg represented a decline of 10.5% (8.7kg) over a three month period (February to May, 2014). June weight of 73.6kg represented a decline of 8.8% (7.1kg) over a three month period (March to June, 2014).

In the Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment, completed on a specified day in May 2014, weight loss was coded, but was not assessed in the written RAP.

Resident #9's weight was assessed on a specified day in August 2014 when the RD charted that "Resident has had a significant wt loss…" By this time, the resident's weight had declined 12.7% over a six month period (February to August, 2014). It was at this time that the resident was identified as being at high nutritional risk by the RD.

Resident #9's current weight is 70.1kg which represents a loss of 13.1% (10.6kg) over a six month period (March to September, 2014). This weight change has not been assessed by the RD.

C) Resident #15 was admitted to the home in November, 2013. A review of the resident's health care record indicates that from admission to June, 2014, the resident experienced gradual weight loss of 4.3% (3.6kg).

The Vital Signs section of Resident #15's chart list the following weights:
A specific day in June 2014 - 80.5kg
A specific day in July 2014 - 61.2kg.

This represents a decline of 24% (19.3kg) over a one month period. In a progress note entry on a specific day in July 2014, the RD queried the accuracy of the July weight and requested a re-weight. The weights charted subsequently are:
A specific day in August 2014 - 59.8kg
A specific day in September 2014 - 59.3kg.

Resident #15's weight was assessed on a specified day in August 2014, 7 days after the August reweigh, when the RD charted " Resident receives Boost Plus 1.5 1 bottle @ Bkfst. Resident was in hospital and has had a sign wt loss. Current wt-59.8kg/BMI-26 is now with his/her IBW range 55.4-67kg. Resident has stage III ulcer. Writer may put resident on med pass program-Resource 2.0 60ml QID. Resident remains high nutritional priority".

According to Resident #15's current care plan, the resident is at high nutritional risk, consumes a puree texture diet and receives supplemental Boost once daily.

Resident #15's current weight of 59.3kg which represents a loss of 0.8% in one month, 26.3% (21.2kg) in three months and 27.6% (22.6kg) in six months. Resident #15's chart was reviewed, and these weight changes have not been assessed by the RD. [s. 69. 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 the weight changes identified in March 2014 for Resident #8 and in September 2014 for Residents #9 and #15 are assessed and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

A review of the home's Tuberculosis screening process was conducted as part of the RQI.

On September 25, the Assistant Director of Care indicated to Inspector #592 that the Tuberculosis screening was changed a few months ago, therefore residents over 65 years old were no longer required Tuberculin testing but a chest x-ray was to be done 90 days prior to the admission to the home.

Inspector #592 reviewed three residents' health care records for Tuberculosis screening. Two residents were noted not to have been screened within 14 days of the admission.
- Resident #19 was admitted to the home on a specified day in June 2014. Tuberculosis screening was not done until a specified day in July 2014, which is 24 days post admission.
- Resident #18 was admitted to the home on a specified day in September 2014. No information was found in the resident's chart for tuberculin skin test or chest x-ray.

On September 25, a Registered Practical Nurse, staff member S#106 stated to

Inspector #592 that Resident # 18 was under 65 years, therefore any resident under 65 years old does not require any chest-x-ray or tuberculin screening if they don't trigger as being positive on screening tool software.

On September 26, the Assistant Director of Care indicated to Inspector #592 that she was unable to provide any x-ray or tuberculin skin test for Resident #18. She indicated that the home was waiting for their updated policy which was just received in August and that in the meantime it was a grey area with their Public Health Unit for the guidelines for tuberculin screening or chest x-ray requirements.

Upon showing to the Assistant Director of Care the immunization screening date for Resident #19, she indicated to Inspector #592 that the resident was not screened within 14 days of admission as per their home policy. [s. 229. (10) 1.]

2. The licensee has failed to ensure that residents are offered immunization against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

On September 25th, 2014 Inspector #592 reviewed three residents' immunization consent record and no documentation of tetanus or diphtheria were found for Resident #18, #19 and #20.

On September 25th, 2014 upon an interview with Registered Practical Nurse staff member S#112 on third floor, the staff member indicated to Inspector #592 that the home does not offer diphtheria/tetanus immunization to residents and therefore they are not available on site.

On September 26th, 2014 the Assistant Director of Care (ADOC) indicated to Inspector #592 that the home was not offering to residents the diphtheria/tetanus immunization. The ADOC indicated that the home is working actively to offer these immunization to their residents and that the home did received new consent forms which will be implemented shortly. [s. 229. (10) 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 that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee; and that residents must be offered immunizations against Tetanus and Diphteria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that O.Reg. 79/10, s. 50 (2) (b) (iii) which states that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds: be assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration have been implemented.

Resident #10 is identified as having fragile skin and is at high risk of skin breakdown. On a specified day in December 2013, Resident #10 developed a stage 3 pressure ulcer to a hip. Nursing staff assessed the wound and implemented wound care interventions.

One month later, on a specified day in January 2014, the home's Registered Dietitian (RD) assessed the resident's dietary needs. The RD documented in the Resident Assessment Protocol (RAP) that " The Resident is on a regular diet, puree texture, regular fluids. Writer will start resident on med pass program- Resource 2.0 60ml QID/Liquid Prosource 30ml @0800hrs to help with skin integrity-stage III ulcer. Residents current wt is inaccurate and resident needs to be reweighed. Resident will remain high nutritional priority."

A review of resident's health care record and dietary orders shows that no dietary supplements were ordered on that specified day in January 2014. Resident #10 was reassessed by the home's Dietary Manager on a specified day in April 2014. She identified that the resident still had a stage 3 pressure ulcer. Five days later, the Dietary Manager completed a Nutrition Priority Screening for the home's RD to reassess Resident #10 as the resident had a low Body Mass Index (BMI), a hip ulcer and poor intake. The RD reassessed the resident on a specified day in April 2014, 20 days after the referral from the Dietary Manager. At that time the RD ordered a dietary supplement, Resource 2.0 60 ml po QID to help with healing of the resident's wound. This was implemented on that same day in April 2014.

On October 1, 2014, Resident #10's dietary assessments were reviewed by Inspector #117 with the home's Registered Dietitian. She confirmed that the specified day in January 2014 the RAP documented that a dietary supplement was to be started to help with the healing of the resident's stage 3 wound. However, the RD did not order the dietary supplement at that time and the recommended dietary interventions were not implemented until the resident was reassessed by the RD on a specified day in April 2014. [s. 50. (2) (b) (iii)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of a between meal beverage in the morning.

Residents on the fourth floor (Forest Unit) reported not being offered a between meal beverage in the morning.

The "MOH Inspection Binder" presented to the Inspection Team states that "AM hydration" is at 10:45. The PSW Days binder was reviewed, and indicates that each day a PSW working a particular section is assigned to set up collation, and all are to help pass.

Inspector #551 was present on the fourth floor from 10-11am on September 26, 2014, from 10:10-11:30am on September 29, 2014 and from 10:10-11:30 on October 1, 2014.

On each of these days, the following was observed: Residents were sitting across from the elevator and in the dining room. A nourishment cart was not circulated, and residents in their rooms or sitting in common areas on the fourth floor were not offered a between meal beverage. [s. 71. (3) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written report be provided to the Director within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse of a resident. [Log # O-0000503-14]

As per the home's Critical Incident Report, Resident #22 was observed by RN S#124 inappropriately touching Resident #3's breasts on a specified day in May 2014.

A Critical Incident Report outlining the incident and the investigation was submitted to the Director on a specified day in June 2014, 12 days later.

During a meeting with the Director of Care and the Administrator on October 2, 2014 it was confirmed to Inspector #549 that the written report of the alleged, suspected or witnessed incident of abuse of Resident #3 was not submitted to the Director within 10 days of becoming aware of the incident. [s. 104. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 36.	CO #001	2014_286547_0018	547
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2014_288549_0021	549

Issued on this 6th day of October, 2014

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