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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 24, 2015	2015_295556_0015	O-001657-15, O-002023-15, O-001761-15	Complaint

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

WENDY PATTERSON (556)

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): May 25, 26, 27, 28, 29, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Substitute Decision Makers (SDM).

The Inspector reviewed resident health care records, the home's internal investigation documentation, risk management reports, observed resident staff interaction, and resident care areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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).

Findings/Faits saillants :

1. The licensee failed to provide Resident #001's SDM with an opportunity to participate when the Resident was reassessed and the resident's plan of care was revised.

On May 25, 2015 during the course of an inspection Resident #001's health care record was reviewed and indicated that Resident #001's daughter was the Resident's Substitute Decision Maker (SDM), and Power of Attorney for Care (POA).

In an interview Resident #001's SDM stated that while Resident #001 resided in the home the resident was over medicated with an antidepressant causing excessive drowsiness, and that the home did not notify her when they changed Resident #001's medications or treatments.
Resident #001's health care record indicated that on:
-a specified date an antibiotic was ordered for the treatment of an infection, however there was no documentation in the health care record to indicate that Resident #001's SDM was notified of the Resident's new infection, or the prescribing of the antibiotic.
-three specified dates Resident #001's medication dosage was changed, however there was no documentation to indicate that Resident #001's SDM was notified of the change in medication.
-a specified date an antibiotic was again ordered for Resident #001 for the treatment of an infection, and on the following day there was a progress note indicating that Resident #001's SDM, who was visiting the resident, was very upset that she had not been notified of the change in condition and order of an antibiotic.

In an interview RPN #100 stated that when there is a new order, or a change in an order for medication or treatment, or a change in condition of a resident the RPN on duty calls the SDM. RPN #100 further stated that every call made to a SDM is documented in the progress notes in the Resident's health care record and if there is no documentation then a call was not made.

In an interview the DOC stated that the Registered Staff on the unit is responsible for contacting the SDM when there is a change in medication, a change in treatment, or a change in health status of a resident. The DOC further stated that the Registered Staff are to document in the Resident's health care record once the SDM has been contacted, or a message has been left. [s. 6. (5)]

Issued on this 24th day of June, 2015

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

Original report signed by the inspector.