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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## 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 |
|---|---|---|---|
| Oct 28, 2016 | 2016_290551_0020 | 019524-16, 023867-16 | 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 WEST END VILLA
2179 ELMIRA DRIVE OTTAWA ON K2C 3S1

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

MEGAN MACPHAIL (551)

### 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): August 22-26, 2016.**

**The following logs were inspected: 019524-16 (concerns about the care of a resident), 023867-16 (concerns about the care of a resident).**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, Housekeeping Staff, the Registered Dietitian, the Assistant Director of Care, the Director of Care and the Administrator.**

**During the course of the inspection, the inspector(s) reviewed health care records, observed residents and residential areas, reviewed selected policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Hospitalization and Change in Condition**
**Nutrition and Hydration**
**Personal Support Services**
**Responsive Behaviours**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001's weight declined significantly during a one month period. On a specified date, the Registered Dietitian (RD) ordered an oral supplement, and approximately two weeks later weekly weights were ordered.

Resident #001's weight continued to decline. On a specified date, a food intake study for one week was ordered, and the resident's diet was changed to a modified texture. On a specified date, the oral supplement was discontinued and a different supplement was ordered.

The RD was interviewed and stated that she did not contact resident #001's SDM to inform him of the resident's weight loss and the subsequent interventions that were put in place.

Resident #001's SDM stated that no staff member informed him of the resident's weight loss. The resident's SDM stated that he was not informed when an oral supplement was initiated or changed, when weekly weights were ordered, when a food study was ordered or when the resident's food texture was changed, as he would have wanted. [s. 6. (5)]

2. The licensee has failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

According to the flow sheets, resident #001 requires total assistance for bed mobility, transferring and toileting.

A review of resident #001's health care record indicates the presence of altered skin integrity, including:

- On a specified date: an acquired wound to a specific body part, and a treatment was initiated.
- On a specified date: a skin tear to a specific body part, and a treatment was initiated.
- On a specified date: the previously acquired wound to the specific body part closed, and new onset of redness to a specific body part. One treatment was discontinued and a new one was initiated.
- On specified dates: new onset and deterioration of the wounds
- On a specified date: new wound to a specific body part, and treatment was initiated by RPN #108.
- On a specified date: enterostomal therapist (ET) assessment due to impaired skin integrity, and the ET recommendations were implemented three days later.
- On a specified date: ET reassessment, and recommended treatments initiated.
- On a specified date: resident #001 was sent to the hospital. Resident #001 returned to the home on a specified date with specific diagnosis.

Resident's SDM stated that he was not kept aware of the resident's skin conditions. The SDM stated that he was not aware of the seriousness of the resident's skin condition until the resident's hospitalization when a hospital staff member spoke to him about it.

RPN #108, the home's wound care nurse stated that she develops and implements the skin treatments and that the RN who is in charge of the floor is responsible for keeping the family up to date.

The Physician's Order sheets (digital pen) were reviewed, and the tick box for POA Notified is consistently blank. There was no documentation in the progress notes to indicate that the SDM was notified of the resident's skin condition and given an opportunity to participate in the development of the plan of care. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided

to resident #001 as specified in the plan.

Resident #001's weight declined significantly during a one month period and continued to decline during the next month.

On a specified date, the RD ordered weekly weights, and approximately two weeks later, she ordered a food intake study.

According to the vitals signs section of the chart, following the RD's order, resident #001's weight was recorded three times.

A weekly weight was not taken on five occasions.

On a specified date, the physician charted that weekly weights were not being taken as ordered. The RD stated that the food intake study was not completed as ordered. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

As noted in #2. above, resident #001 had a wound on a specific body part and then developed a wound on another body part. The resident was assessed by the enterostomal therapist (ET) on specific dates, and recommended treatments were initiated.

RPN #108 stated that on a specified date, she went to provide the resident's wound care and noticed that the wrong treatment had been applied to the wound on a specific body part. The treatment that was ordered for one body part had been applied to the other. The RPN stated that who and when the incorrect treatment was applied was unknown as the last two scheduled treatments to the specific body part were coded Dry and Intact on the Treatment Administration Record (TAR). A review of the progress notes shows that an entry was written four days before RPN #108's treatment stating that the dressing to two wound sites had been changed as they were wet.

On a specified date, RPN #108 charted that the wound to a specific body part had deteriorated, and a new treatment was initiated.

The following day, the resident was sent to the hospital. Resident #001 returned to the

home nine days later with specific diagnosis. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented with regards to resident #002's bathing care.

According to resident #002's plan of care and the bathing schedule, the resident is bathed twice weekly. The provision of bathing care is documented on the flow sheet.

Resident #002's flow sheets were reviewed for a period of approximately three months. Of the twenty three times during this period when resident #002 was scheduled to receive bathing care, the provision of the bathing care was not documented four times, including three times in a row. The progress notes on these days were reviewed, and there is no documentation with regards to the resident's bathing care.

The ADOC stated that the provision of bathing care should be documented on the flow sheet, and if it was refused by the resident, there should also be a progress note entry. [s. 6. (9) 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 that resident #001's SDM is given the opportunity to participate fully in the development and implementation of the resident's plan of care; to ensure that care is provided to resident #001 as specified in the plan; and to ensure that the provision of resident #002's care is documented, to be implemented voluntarily.***

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**WN #2: 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 resident #001, exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds, received 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.

RPN #108, the home's wound care nurse stated that the home's clinically appropriate assessment instrument that is specifically designed for skin and wound assessment is titled Weekly Wound Assessment - includes Bates-Jensen - V 5.

A review of resident #001's health care record indicates the presence of altered skin integrity on an ongoing basis.

A review of resident #001's health care record, during a specific time period, indicates that a Weekly Wound Assessment - includes Bates-Jensen - V 5 was completed on nine occasions.

A Weekly Wound Assessment - includes Bates-Jensen - V 5 was not completed when resident had altered skin integrity during specific time periods, including:

- nine consecutive weeks when the resident exhibited altered skin integrity

- four consecutive weeks when the resident exhibited altered skin integrity
- two consecutive weeks on two occasion when the resident exhibited altered skin integrity

The Treatment Administration Records (TAR) for a specific period of time were reviewed, and for each month there is a weekly order for wound measurement and record to PCC (Point Click Care). RPN #108 stated that the order for wound measurement and record to PCC meant complete the Weekly Wound Assessment - includes Bates-Jensen - V 5 which would then auto populate a note to the progress notes. RPN #108 verified that the Weekly Wound Assessment - includes Bates-Jensen - V 5 was not completed weekly while the resident was exhibiting altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #001 was assessed by a registered dietitian who is a member of the staff of the home when the resident exhibited altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds.

Resident #001 exhibited altered skin integrity on a specified date, and was not assessed by the RD until the end of the following month when the wound had resolved. [s. 50. (2) (b) (iii)]

***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 exhibiting altered skin integrity receive 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; and to ensure that residents exhibiting altered skin integrity are assessed by the registered dietitian (RD), to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's antibiotic resistant organism (ARO) policy was complied with.

As per O. Reg 79/10, s. 8 (1) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

On a specified date, following resident #001's admission to the home, cultures were taken. A result was received indicating that a specific ARO was isolated.

On two occasions, cultures were taken and both were negative for the specific ARO.

There is no record of a third negative culture. The Administrator confirmed that a third swab was not done based on the home's records.

The home's policy IC-05-01-03, last updated September 2016, directs care staff to: Take three cultures at least one week apart or as directed by your local public health authority. Contact precautions can only be discontinued after 3 consecutive negative samples. [s. 8. (1)]

**WN #4: 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 has failed to ensure that the following weight changes were assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated:
1. A change of 5 per cent body weight, or more, over one month.
2. A change of 7.5 per cent body weight, or more, over three months.
3. A change of 10 per cent body weight, or more, over six months.
4. Any other weight change that compromises the resident's health status.

Soon after resident #002's admission to the home, the resident was ordered an oral supplement. Approximately four months later, the resident's weight declined significantly over a one month period.

The weight loss was assessed by the RD, however no actions were taken to address it. The resident's weight continued to decline and represented a significant change compared to six months prior. The weight loss was assessed by the RD, however no actions were taken to address it.

On two occasions, the resident experienced significant weight gains. The weight change was assessed by the RD, however no actions were taken to address it.

Resident #002's weight in a specified month represented a significant gain over six months. The heath care record was reviewed, and there is no indication that the weight gain was assessed and that actions were taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

**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, (a) three meals daily; O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #002 was offered three meals daily.

According to resident #002's plan of care, he/she is assessed as being at high nutritional risk and specific interventions related to nutrition are in place.

On a specified date, it was noted that resident #002 did not come to the dining room for lunch.

PSW #102 stated that when resident #002 refuses to come to the dining room, a meal is not provided for him/her to eat in his/her room. After the lunch meal service had concluded, PSW #102 stated that resident #002 had refused to come to the dining room for lunch, and a tray was not provided. RPN #104 stated that when resident #002 refuses to come to the dining room for a meal, she gives him/her extra liquid oral supplement to replace the meal. A progress note entry on a specified date stated that the resident had refused lunch and had accepted liquid oral supplement.

The resident's plan of care states that when resident #002 refuses to go to the dining room, staff are to bring his/her meal to his/her room and supervise him/her while eating. [s. 71. (3) (a)]

**Issued on this 28th day of October, 2016**

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

**Original report signed by the inspector.**