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

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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 12, 2018	2018_683126_0005	013026-17, 013328-17, 018809-17, 020938-17, 021748-17	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

LINDA HARKINS (126)

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): February 28, March 8, 9, 12, 13, 14, 15 and 26, 2018.

During this inspection the following complaint logs related to care and services were completed:
Complaint logs 013026-17, 013328-17, 018809-17, 020938-17, 02748-17 related to care and services given to residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Clinical Coordinator, the Infection Control Nurse, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers, (PSW), the Social Worker, the Environmental Manager, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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).

Findings/Faits saillants :

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

On a specific date in March, 2018, resident #004 indicated to Inspector # 126 that they had two loose stools during the night and that it was reported to the night shift nursing staff.

On that specific date in March 2018, Registered Practical Nurse (RPN) #115 documented in the Home's Daily Report Sheet (DRS), that resident #004 had two loose stools during the night shift.

On that specific date of March 2018, Registered Nurse (RN) #110 documented in the progress notes that resident #004's Substitute Decision Maker (SDM) called on that date and informed them that the resident had a loose stool that morning. It was documented that resident #004 was to be monitored closely for repetitive episodes.

On that specific date of March 2018, it was documented on the Personal Support Worker (PSW) Daily Flow Sheet (DFS) that on the night shift resident #004 had no bowel movement, that resident had a normal bowel movement on the day shift and had a small normal on the evening shift.

Resident #004 was on a one dose of daily evening laxative. It was noted in the Medication Administration Record (MAR) of that specif date, the evening laxative was administered by RPN #115. RPN #115 indicated that the laxative was given the evening of that specific date of March 2018. The next day, RPN #115 indicated to Inspector #126 that they could not recall being told that resident #004 had loose stool during that previous night and day shift.

Discussion held with the evening RN #109 who indicated that this information should have been communicated either at the change of shift report or should have been documented on the DRS.

Resident #004 had loose stools on a specific date of March 2018 and information was inaccurately documented in the DFS and the information was not communicated to the evening shift to ensure their assessments were integrated, consistent with and

complement each other. [s. 6. (4) (a)]

2. On a specific date in July 2016, it was documented in the progress notes that resident #004 was exhibiting some responsive behaviours such as calling the police, was angry, upset and appeared very confused. RPN #117 collected a urine sample for Culture and Sensitivity (C&S). The urine sample was put in the fridge of a specific unit for the laboratory to pick up the next day.

The next day, resident #004's physician #118 visited the resident. There was no documentation that the physician was aware that a urine sample was collected on the previous day. It was documented in the progress notes that resident #004 was asymptomatic for 5 days and after those days, the resident started to complain of pain and burning in a specific area. On that day, Physician #118 ordered a urine sample for C&S as the resident was presenting with a possible urinary tract infection.

Another urine culture was collected three days after the Physician visit.

Four days after collecting the urine, it was documented in the progress notes that RN #108 had a discussion with resident #004's family members who were expressing concerns regarding the urine sample result and treatment as the nursing staff on the unit could not find the urine sample result. Later that evening, the urine result was found on the unit and was positive.

On that specific date of July 2016, it was documented in the progress notes that RPN #119 called the laboratory for the result of the urine culture. The on call physician was informed of the result and prescribed antibiotics. The first dose of antibiotic was given one hour later.

The license has failed to ensure that staff and others involved in the different aspects of care when collecting urine sample and obtaining result collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible and responded within 10 days.

Resident #004’s family member sent an email on a specific date in February 2018, to Director of Care (DOC) #114 expressing several concerns related to care and services.

Discussion held with DOC#114, indicated that the concerns were investigated and followed up on if needed but did not respond to the family member within 10 days.

The family member email sent to DOC #114 was reviewed by Inspector #126. It was noted that the concerns were investigated but there was no response within 10 days of the receipt of the email. [s. 101. (1) 1.]

Issued on this 12th day of April, 2018

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

Original report signed by the inspector.