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 prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2018_665551_0008	002427-18, 002819-18, 005158-18, 009518-18, 016154-18, 025972-18, 027803-18, 028021-18, 028584-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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): December 18, 20 and 21, 2018 and January 2, 3, 4, 7, 8, 9, 10, 11, 15, 16, 17 and 18, 2019.

The following inspections were completed:
- log 0024271-18 related to the care of a resident.
- log 002819-18 related to the care of a resident. Log 002767-18 / Critical Incident System (CIS) 2707-000003-18 was inspected concurrently with complaint log 002819-18.
- log 005158-18 related to the care of a resident.
- log 009518-18 related to the care of a resident.
- log 016154-18 related to the care of a resident.
- log 025972-18 related to an allegation of abuse.
- log 027803-18 related to the discharge of a resident.
- log 028021-18 related to the care of a resident.
- log 028584-18 related to the care of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), including a Behavioural Supports Ontario (BSO) PSW, Registered Nursing Staff, Clinical Coordinators, a Registered Dietitian (RD) the Nutritional Manager, the Support Services Manager, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed health care records and selected policies and procedures, observed meal service, toured the laundry and observed staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Admission and Discharge
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
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.

5 WN(s)
4 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	Légende 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).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that staff collaborated with each other in the assessment resident #002 so that their assessments were integrated, consistent with and complimented each other.

As part of the Minimum Data Set (MDS) assessment for a specified Assessment Reference Date (ARD), resident #002's skin condition was assessed and was noted to be free of any pressure ulcers, other skin problems and lesions.

On the morning of a specified date, the resident was assessed by RN #119 due to the presence of bruising. The resident was sent to hospital for further assessment and returned that evening.

On a specified date, RN #134 charted a late entry for four days earlier, indicating that the RN had been informed by a PSW that the resident had bruising to a specified body part.

According to the DOC who investigated the resident's bruising, RN #134 did not chart a progress note or communicate the bruising when it was reported, therefore no further assessment or monitoring was completed by the registered staff until three days later when the bruising required a visit to the emergency room.

Staff did not collaborate in that RN #134 did not communicate the bruising that was reported on a specified date. [s. 6. (4) (a)]

2. The licensee failed to ensure that resident #009's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

On a specified date, the physician ordered a new medication for resident #009.

According to resident #009's SDM, they were not notified before the medication was initiated.

A review of the eMAR indicated that the section that says Consent under Nurse: Please initial the Document as Performed was blank.

Resident #009's SDM was not provided the opportunity to participate fully as they were not consulted before the new medication was implemented. [s. 6. (5)]

3. The licensee failed to ensure that care was provided to resident #003 as specified in the plan.

A review of resident #003's health care record indicated that on the day of admission, two short bed rails for repositioning were ordered.

Approximately two weeks later, resident #003 was transferred to a different floor. On the day after the move, the resident was found on the floor and sustained an injury. The resident was sent to hospital.

RPN #127 was interviewed and stated that they were working when resident #003 fell. The RPN stated that the resident had fallen out of bed.

RN #109 was interviewed and stated that they received the resident upon return from the hospital. The RN stated that the bed that the resident had been transferred to did not have bed rails.

Care was not provided to resident #003 as specified in the plan as when the resident was transferred to a different floor, the bed did not have bed rails as ordered by the physician, and the resident fell out of bed and required a visit to the emergency room. [s. 6. (7)]

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 collaborate with each other in the assessment of residents; to ensure that residents' SDMs are provided with the opportunity to fully participate in the development and implementation of the plan of care; and to ensure that care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed using a clinically appropriate assessment instrument that is specifically designed for falls.

According to the DOC, the home's clinically appropriate assessment instrument is Post Fall Assessment in the Assessment section of Point Click Care (PCC) and a Falls Incident Report in Risk Management in PCC, and that these two assessments are to be completed after each fall.

On two specified dates, resident #005 sustained falls.

A review of the resident's health care record indicated that after both falls, an Incident Report in Risk Management was completed, and a Post Fall Assessment was not. [s. 49. (2)]

2. A review of resident #003's health care record indicated that after the resident sustained a fall on a specified date, a Post-Fall Assessment was completed, and a Falls Incident Report in Risk Management was not. [s. 49. (2)]

3. On two specified dates, resident #007 sustained falls.

A review of the resident's health care record indicated that after the first fall, an Incident Report in Risk Management was completed, and a Post Fall Assessment was not. After the second fall, neither an Incident Report in Risk Management or a Post Fall Assessment were completed. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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 resident #003's weight loss was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Resident #003's weight was taken upon admission to the home.

In the MDS assessment completed in the first quarter after admission, the Resident Assessment Protocol (RAP) for Assessment Protocol (AP) #12 Nutritional Status was triggered because the resident was leaving 25% or more of food uneaten at most meals. In the RD's assessment, it was noted that the resident refused meals, supplements, medications and care, and the resident's admission weight was noted to be the most recent.

Approximately three months after the resident's admission, "Resident refuses to be weighed" was added to the written care plan.

After the initial weight, resident #003 was not weighed again for five months. When resident #003's weight was taken, it showed a significant loss. Resident #003's weight declined again the following month representing a significant loss overall in the first six months since being admitted to the home.

Approximately six weeks after resident #003's new weight was recorded, RD #133 assessed resident #003's weight and noted that the resident was eating 77% percent of their meals, refused supplements, and no changes were made to the care plan.

According to RD #100, the home's interventions to address weight loss may include double or large portions, liquid protein or oral supplements.

When the resident refused oral supplements, no other actions were taken and outcomes evaluated to address the resident's weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 weight loss as specified in O. Reg 79/10, s. 69 (1) (2) (3) and (4) is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber.

On a specified date, resident #005 was sent to hospital and was admitted for several days. The resident returned with a specified diagnosis and an order for a specific treatment.

A review of the eMAR on a specified date at a specific time, indicated that the box was blank. According to the DOC, this means that the dose of the treatment was not given.

Resident #005's treatment was not administered as prescribed on a specified date at a specific time. [s. 131. (2)]

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 drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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 failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

Resident #009 was admitted to the home for a respite stay.

A progress note indicated that when the resident's SDM came to pick up the resident, they expressed several concerns, including with regards to missing clothing. According to the progress note, the plan was to look in the laundry and phone the SDM if anything was found. A progress note written the following day indicated that some clothing had been located.

Approximately five weeks after the resident's discharge, the home's Administrative Assistant (AA) sent an email to resident #009's SDM specific to the respite stay.

In the SDM's email response to the AA on the same day, the SDM stated that clothing remained missing and there was "still no word or what or where these are."

The AA and resident #009's SDM exchanged several more emails on this day, and that was the end of their correspondence.

Approximately four weeks later, the resident's SDM sent an email to the AA. In it, it was stated that several emails had written with no response received with regards to the resident's clothes that was missing from their respite stay several months earlier. In this email, a bruise on the resident was also brought forward.

The SDM's email was forwarded to the Support Services Manager and the Office Manager, and then to the DOC who sent the email to the Administrator.

The Administrator then replied to the resident's SDM via email and began an investigation into the concerns.

The SDM's written complaint to a staff member on a specified date was not resolved and a response was not provided to the complainant within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

Issued on this 19th day of February, 2019

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

Original report signed by the inspector.