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
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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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
Oct 16, 2018	2018_702197_0019	019094-18	Critical Incident System

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 29, 30, September 4, 2018

The following intake was inspected as part of this report:
log 019094-18 - critical incident # 2709-000015-18 related to the choking and subsequent death of a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Care Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Registered Dietitian, the Food Service Supervisor, the Office Manager, the Unit Clerk, the Program Manager, a restorative care PSW and residents.

The inspector also reviewed a resident's health care record and an internal investigation file.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 licensee has failed to ensure that staff and others involved in the different aspects of care for resident #001, collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On a specified date, Resident #001 was served their meal. The resident started to eat and soon after began to choke. The RPN documented that the resident was removed from the dining room and that they started the Heimlich maneuver. The RN documented that they attempted an initial finger sweep of the resident's mouth but this was unsuccessful. The RN then attempted a 2nd finger sweep and was able to remove a piece of food. At this point the RN charted that the resident was unresponsive. Progress notes indicate that the resident passed away the same day, a short time after the incident.

Since the resident's admission, their diet order had been regular diet, regular texture, regular fluids.

The resident's last updated care plan before the incident, indicated the following: RESOLVED: EATING: Staff to remind resident to go to meals in dining room. Staff to set up & cut up meats.

During an interview with the Director of Care, they indicated that the home is in the process of moving all Activities of Daily Living (ADL's) into Point-of-Care (POC) in Point Click Care, the home's electronic record, as opposed to having this information in the written care plan.

RPN #100 indicated in an interview that they had moved all of resident #001's ADLs over to POC, which is why the last updated care plan indicates "resolved". They said in the process they called up to the floor where resident #001 resided and spoke to a PSW, whose identity they could not recall. This PSW told them that resident #001 did not need their meat cut up and so RPN #100 took this statement out of the plan of care for the resident. RPN #100 also indicated that it was PSW #101 who had initially put this intervention into place and had dictated it to the program manager to put into the computer.

PSW #101 was interviewed and confirmed that they had put this intervention into resident #001's care plan instructing staff to cut up the resident's meat, but stated it was

meant more for hotdogs and hamburgers since the resident had a hard time handling these types of food. When asked if they felt other types of meats needed to be cut up for the resident, they said no. PSW #101 further indicated that resident #001 would eat very quickly and at times, needed to be reminded to eat slowly. PSW #101 acknowledged that the wording was not clear in the care plan as to why resident #001's meat needed to be cut up. The PSW was not able to provide an assessment or notes as to why this care plan decision was made and the inspector was not able to find any related progress notes.

During the inspection, Food Service Supervisor #102 was interviewed and indicated that the diet information they had for the resident did not indicate that their meat needed to be cut up and they could not recall this ever being mentioned to them.

Registered Dietitian (RD) #103 also stated that they were never made aware at any time that the resident needed their meat cut up. The RD did state that resident #001 was known to put food into their mouth very quickly at times.

The RN, RPN, 3 of the 4 PSW's, the dietary aide and two residents that were present the day the resident choked were interviewed by the inspector.

PSW #104 indicated that they do not work on the floor where resident #001 lived very often, so was not as familiar with the residents there that day. They said they were unsure if the resident's meat had been cut up and unsure if the meat should have been cut up.

PSW #105 was the PSW who served resident #001 their meal that shift. They stated that they started to work in the home about 2 months ago and was also not very familiar with the residents on the floor where resident #001 lived. They stated that they were not told about any specific interventions for resident #001, but after they gave the food to the resident and they choked, another PSW(#106) on the floor told them that resident #001's meat should have been cut up. PSW #105 confirmed that they did not cut up any food on resident #001's plate before giving it to them.

PSW #106 told the inspector that usually staff cut up the food for resident #001. They stated that staff have to tell the resident to slow down as they eat very quickly. PSW #106 said that staff that work on this floor know the resident eats very fast. They also stated that resident #001 could not cut up their food on their own and so this is why staff would do it.

Dietary Aide #107 stated that typically staff would cut up the resident#001's meat, for example a pork chop or steak. They said the meat on the day the resident choked was soft and stated they weren't sure if it should have been cut up for the resident.

RPN #108 stated that resident #001's meat should have been cut up by staff. They indicated that resident #001 took a bite of the meat immediately when the PSW sat the plate down in front of them.

RN #109 was called to the dining room when resident #001 was choking. At one point, this RN was successful in clearing a piece of the meat out of the residents mouth. The RN said she knew resident #001 well, but due to the fact that they typically work nights they could not say if the resident required their meat to be cut up by staff.

RPN #110 indicated they knew resident #001 well and stated they do eat independently. They stated that they assumed that staff cut up the resident's food for them and stated the resident would need everything to be set up for them. They said that when they used to help in the dining room they would cut up resident #001's food. They felt the care plan should have said "set up help" which meant to cut up food and open cartons.

At this time the inspector noted that in the last updated care plan before the incident, it had indicated "staff to set up", but this statement was also removed and was no longer reflected in POC at the time the choking incident occurred.

Two residents who resided on the same floor as resident #001 were also interviewed.

Resident #002 said they were not in the dining room at the time resident #001 choked, but said they recalled staff cutting up resident #001's food at meals. They said that resident #001 would not have been able to cut up their own food. Resident #002 went on to say that they didn't think that resident #001's food had been cut up by staff the day they choked.

Resident #003 told the inspector that they had a good view of the resident when they choked. They stated they first heard resident #001 coughing and stated the resident could not answer when staff spoke to them. Resident #003 said they knew that staff were supposed to cut up the resident's food, but was unsure if their food was cut up at that meal. They stated that they felt one of the issues was that this was a time when most of the staff on the floor were not regular staff.

Three other PSW's from the floor where resident #001 resided, were interviewed on a particular shift. PSW #111 indicated that they knew resident #001 and that their food was cut up by staff before giving it to them. They went on to say that the resident used to be independent but was changed to have more supervision.

PSW #112 also indicated that they were familiar with resident #001's care and that they would have cut up the resident's food before giving it to them. When asked how they would know to do this, they said they were unsure if it was in the resident's care plan, it was just part of their routine.

PSW #113 said they are a casual PSW on the floor. They said to their recollection staff would cut up resident #001's food for them. The PSW stated they thought this was because the resident had started to decline.

During an interview with the Administrator of the home they stated that to their knowledge, they did not feel that resident #001 would need their meat cut up. They further stated that they had never been made aware that the resident needed to have their food or meat cut up and was unaware staff were doing this. The Administrator said the first time they were hearing about this was from the Program Manager for the home who told them after the resident had passed away that resident #001 had been seen a couple of times "stuffing" food in their mouth.

Staff and others involved in the different aspects of resident #001's care did not collaborate with each other in their assessment of the resident's eating abilities and associated risk factors. This lack of collaboration resulted in inconsistencies in how care was provided to the resident. [s. 6. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 15th day of November, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2018_702197_0019
Log No. / No de registre :	019094-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 16, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare West End Villa 2179 Elmira Drive, OTTAWA, ON, K2C-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Keeler

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The licensee shall comply with LTCHA 2007, s. 6(4).

Specifically, the licensee shall ensure that changes to dietary interventions in residents' plans of care are:
- discussed with the interdisciplinary team and that these discussions are documented and
- communicated to all staff and others involved in different aspects of the resident's care and that any changes are consistent and complement each other

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #001, collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On a specified date, Resident #001 was served their meal. The resident started to eat and soon after began to choke. The RPN documented that the resident was removed from the dining room and that they started the Heimlich maneuver. The RN documented that they attempted an initial finger sweep of the resident's mouth but this was unsuccessful. The RN then attempted a 2nd finger sweep and was able to remove a piece of food. At this point the RN charted that the resident was unresponsive. Progress notes indicate that the resident passed

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Staff and others involved in the different aspects of resident #001's care did not collaborate with each other in their assessment of the resident's eating abilities and associated risk factors. This lack of collaboration resulted in inconsistencies in how care was provided to the resident.

The decision to issue this non-compliance as a compliance order was based on the following:

The severity of this non-compliance is a level 3 (Actual Harm/Risk) as there was actual harm to resident #001 and they subsequently passed away.

The scope of this non-compliance is determined to be a level 1 (isolated) as resident #001 was the only resident affected.

The home has a level 4 compliance history (Despite MOH action (VPC, order), NC continues with original area) that includes:
- Inspection #2018_683126_0005 (WN, VPC to s. 6(4) a)
- Inspection #2015_288549_0029 (WN, VPC to s. 6(4)b) (197)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Jessica Pattison

Service Area Office / Bureau régional de services : Ottawa Service Area Office