Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 14, 16, 17, 21, 22, 23, Sep 6, 7, 10, 2012	2012_128138_0028	Complaint

Licensee/Titulaire de permis

~~NEW ORCHARD LODGE LIMITED~~ 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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, several registered practical nurses, a registered nurse, personal support workers, food service attendants, residents, family members, and a visitor.
Two complaint inspections were carried out and the inspection occurred on site August 17, 21, 22, and September 6,2012.

During the course of the inspection, the inspector(s) reviewed resident health care records, the home's policy on restraints, the home's policy on abuse, viewed posting of mandatory information, observed two meal services, and observed resident care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

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Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home failed to comply with LTCHA 2007 s. 3. (1) 1. in that a resident was not treated with respect and dignity and in a way that fully recognizes her individuality and respects her dignity.

On a day in May 2012, a visitor to the home observed a resident wander to the nursing station. The resident was overheard by the visitor to express concerns to staff members at the nursing station about being at the home. Three of the four staff members present were overheard to respond inappropriately to the resident, making fun of him/her and laughing at him/her.

2. The home failed to comply with LTCHA 2007 s. 3 (1) 4. in that a resident was not afforded the right to be cared for in a manner that is consistent with her care needs.

On a day in August 2012 a resident was observed in his/her room reclined in his/her wheelchair. The resident's call bell was wrapped around the bedrail closest to the wall and was not accessible to the resident. Upon approach, the resident stated that s/he was not comfortable but not in pain. The call bell was given to the resident which s/he was observed to ring. Several minutes later, a PSW entered the resident's room, removed the call bell from resident's hand and then silenced the call bell. The PSW then proceeded to make the resident's bed but at no point did s/he inquire into the reason the call bell was rung. Subsequently, PSW was observed to leave the resident's room without providing any assistance to the resident.

That same day in August 2012, the resident was observed to ring his/her call bell for a second time, stating again that s/he was uncomfortable but not in pain. A PSW entered the room and was observed to cancel the call bell, stating that the resident always rings the call bell. The PSW was then observed to leave the room without inquiring into the care needs of the resident.

On another day in August 2012 it was observed that the resident was in his/her wheelchair in his/her room along with a different PSW who was making the resident's bed. It was observed that when the PSW left the resident's room the call bell was on the bed and was not made accessible to the resident.

That same morning the resident was heard moaning and upon approach s/he reported that s/he felt like s/he was going to be sick. It was observed that the resident did not have access to his/her call bell as it was on his/her bed out of reach. The call bell was provided to the resident and s/he rang for assistance immediately.

On a day in August 2012 the resident reported to two PSWs in the dining room at the start of the lunch service that his/her shoes were too tight. One of the PSWs acknowledged the resident was wearing sneakers but there was no actions taken to address the resident's discomfort.

On a day in May 2012, a visitor to a resident overheard the resident request assistance to be toileted from a staff member. The visitor reported that the resident was denied assistance to be toileted and instead was told by the staff member that s/he could use the incontinent product s/he was wearing.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The home failed to comply with O. Reg 79/10 s. 110. (2) 4. in that a resident was not released from physical devices and repositioned at least once every two hours.

On a day in August 2012 a resident was observed over two hours sitting in his/her wheelchair with a seatbelt over his/her pelvis and tray top attached to his/her wheelchair. It was confirmed by the unit RN that the resident was unable to release himself/herself from both the seatbelt and tray top. During the period of over two hours, it was observed that the resident was not released from the seatbelt or tray top nor was s/he repositioned during this time despite the resident expressing discomfort and ringing his/her call bell twice for assistance in addressing his/her discomfort.

On another day in August 2012, the resident was again observed over two hours sitting in his/her wheelchair with the seatbelt over his/her pelvis and tray top attached to his/her wheelchair. During this time period it was observed that the resident was not released from the seatbelt or the tray top nor was s/he repositioned.

2. The home failed to comply with O. Reg 79/10 s, 110. (2) 1. in that staff have applied physical devices that have not been ordered or approved by a physician or registered nurse in the extended class.

The unit RN confirmed that a resident is unable to release himself/herself from the seatbelt or the tray top attached to his/her wheelchair. A review of the resident's health record, in consultation with the unit RN, showed that both the seatbelt and tray top were ordered and installed by an occupational therapist after consultation with the resident's family however there was no documentation of a physician's order/approval for the devices.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The home failed to comply with LTCHA 2007 s. 23. (1) (a) (i) in that the home did not ensure every alleged, suspected or witnessed incidents of abuse of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated.

On a day in May 2012, a visitor to the home observed a resident wander to a nursing station. The resident was overheard by the visitor to express concerns to staff members at the nursing station about being at the home. Three of the four staff members present were overheard by the visitor to respond inappropriately to the resident, making fun of him/her and laughing at him/her.
The visitor reported the incident to the residents family who then contacted the home's Director of Care to communicate this incident.
The agenda of the Director of Care showed that a meeting was scheduled with the resident's family. A notation on the agenda indicated that the meeting was in relation to a visitor who witnessed negative behaviours, that the visitor contacted the Ministry, and that this was the second incident.
The resident's family confirmed that the meeting occurred as scheduled and that the incident was further communicated to the Director of Care during the meeting. The family further requested a follow up of the home's investigation from the Director of Care but reported that the family has not received the results of any internal investigation.

Discussions were held with the home's Administrator, Director of Care, and Assistance Director of Care regarding the incident in May 2012 involving a resident. The Administrator, Director of Care, and Assistant Director of Care reviewed their files and were unable to provide any records to support that an internal investigation of the incident had been completed. All stated that they did not have any recollection that the incident had been reported.

Issued on this 10th day of September, 2012

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

Paula MacDonald