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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 9, 2014	2014_362138_0007	O-000254-14	Critical Incident System

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 22 - 23, 2014

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, the Dietary Manager, a Registered Practical Nurse (RPN), a food service worker, and a resident.

During the course of the inspection, the inspector(s) reviewed a Critical Incident Report, reviewed a resident's health care record, reviewed the home's internal investigation documents, toured a dining room and a resident's room.

The following Inspection Protocols were used during this inspection:

Nutrition and Hydration

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. 6. Plan of care

Specifically failed to comply with the following:

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 comply with LTCHA, 2007 S.O 2007, c.8, s. 6. (7) in that the licensee failed to ensure that the care set out in the nutritional plan of care was

provided to the resident as specified in the plan.

The Ministry of Health and Long Term Care received a Critical Incident Report (CIR) that outlined Resident #1 was transferred to the hospital on a day in March 2014 related to an allergic reaction to a food item. The CIR further outlined that the resident had previously been identified by the home as having a severe allergy to a specific food and, at the time of the incident had been provided a menu item containing the identified food by a personal support worker (PSW).

Long Term Care Homes (LTCH) Inspector #138 spoke with Resident #1 who stated to the inspector that s/he recalled the incident in which s/he was transferred to hospital related to an allergic reaction. S/He confirmed that a care giver had provided him/her with food that caused an allergic reaction.

LTCH Inspector #138 spoke with the home's Assistant Director of Care regarding the CIR and the Assistant Director of Care reported to the inspector that the PSW had mistakenly provided Resident #1, who had been known has having a severe allergy to a specific food, a menu item with that specific food in it.

The home's Assistant Director of Care provided LTCH Inspector #138 with the home's internal investigation documents into the incident of March 2014 in which Resident #1 was provided a food that s/he was allergic too. It was noted that the home's Dietary Manager had participated in the investigation into the incident. LTCH Inspector #138 reviewed the internal investigation documents with the home's Dietary Manager. The Dietary Manager stated that the Resident #1 had been identified prior to the incident of March 2014 as having a severe anaphylactic allergic reaction to a specific food and that this information was communicated to serving staff through dietary cards in the dining room. The Dietary Manager was able to demonstrate that the dietary card for serving staff at the time of the incident outlined that Resident #1 had an allergy to this food. In addition, there was notification by way of posted signage in both the dining room and the resident's room at the time of the incident that the resident had a severe allergy as well as a individualized menu in the unit servery for the resident. It was noted on the resident's individualized menu that the menu item the resident was provided was not the menu item indicated on the menu.

Further discussion was held with the Dietary Manager regarding the process for staff ordering the resident meals and she stated that it is the PSWs who will place the order with the resident's name to the food service worker who will plate the food.

Discussion was held with a food service worker on the unit who stated that the dietary cards with resident nutrition information are kept in the dining room and used by the PSWs to place the resident order at meal times. The food service worker further stated that the PSWs are to give the resident's name to the food service worker who is to verify the resident's special nutritional needs such as that with Resident #1. It was confirmed through the home's investigation that the PSW ordered food for the resident without verifying the resident's diet and without communicating the resident's name to the food service worker for further verification.

Further review of the home's internal investigation documents demonstrated that the PSW received disciplinary action for his/her role in the March 2014 incident. [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 nutritional care is provided to Resident #1 was set out by the plan of care, to be implemented voluntarily.

Issued on this 9th day of June, 2014

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

PAULA MACDONALD RP