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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2017	2017_627138_0026	014860-17	Resident Quality Inspection

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 NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE OTTAWA ON K2B 5E6

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

PAULA MACDONALD (138), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 18, 19, 20, and 23, 2017.

The following inspections were completed as part of this Resident Quality Inspection:
Log 034108-16, an incident that causes an injury to the resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
Log 033447-16, an incident that causes an injury to the resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
Log 003083-17, alleged resident abuse;
Log 004441-17, an incident that causes an injury to the resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
Log 023338-17, alleged resident abuse and;
Log 024202-17, related to medication administration.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Assistant Director of Care, the Dietary Manager, the Office Manager, the Resident Program Manager, the Support Services Manager, the Social Services Worker, the President of the Resident's Council, residents, families, registered nurses (RNs), registered practical nurse (RPNs), and personal support workers (PSWs).

The inspector also observed residential areas, observed a medication pass, reviewed internal investigation documents, and reviewed Resident's Council Meeting minutes, and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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 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 resident #041's drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to resident #041 not receiving medications as specified. The complainant indicated that resident #041 did not receive medications crushed as specified on a specific date. The complainant indicated that this issue was brought to the attention of staff and the Administration of the home on other occasions and that it is still not resolved.

Resident #041 was admitted to the home several years ago with specific diagnoses that includes dementia.

During a telephone interview on October 20, 2017 with the complainant it was indicated to Inspector #549 that on a specific date resident #041 was given medications whole that where prescribed to be crushed.

Inspector #549 reviewed resident #041's progress notes for a specific date which indicated that the Substitute Decision Maker (SDM) had requested to the Charge Nurse that the staff be reminded that resident #041 is to have medications crushed, with a few exceptions.

Inspector #549 reviewed resident #041's physician orders for a specific date which indicated medications to be taken need to be crushed and mix with apple sauce.

Resident #041's Medication Review (Chart) Reports for a specific period of time were reviewed by Inspector #549. The Medication Review (Chart) Reports all indicated that resident #041 was to continue to have medications crushed and mixed with applesauce, with a few exceptions. The Medication Administration Record (MARS) for resident #041 for a specific period of time indicated in red to crush medications in applesauce, with a few exceptions.

Resident #041 was assessed by the Registered Dietitian on a specific date to be at nutritional risk and required a fluid modification for safe swallowing.

Inspector #549 reviewed the licensee's investigation documentation which indicated that on a specific date that resident #041 did not receive medications as prescribed. The resident's medications where not crushed, with the exceptions. The licensee's investigation documentation also indicated that on a later specific date, the SDM indicated that the resident's medication where not crushed over the weekend. At the time the SDM did not indicate the date or shift. The licensee investigation documentation

indicated that on another specific date resident #041 did not receive medications as prescribed. The RPN administering resident #041's medications did not crush the medications, with exceptions, as prescribed.

During an interview with the Director of Care (DOC) on October 23, 2017 it was indicated to Inspector #549 that she was aware that resident #041 did not receive medications crushed as specified by the prescriber on three separate specific dates. The DOC indicated that the expectation is that resident #041 receive medications crushed as prescribed. [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 resident #041's drugs are administered as prescribed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a personal assistance service device (PASD) is used to to assist a resident with a routine activity of daily living (in which the resident is not able, either physically or cognitively, to release) only if the use of the PASD is included in the resident's plan of care.

Inspector #549 initially observed resident #017's bed system with two quarter bed rails at the head of the bed in the up position. Inspector #138 also observed, throughout the course of the RQI, that resident #017's bed system had two quarter rails at the head of the bed in the up position. Inspector #138 spoke with PSW #107 regarding the use of bed rails for resident #017 and PSW #107 stated that resident #017 uses the bed rails to assist with transferring in and out of bed with staff assistance. Inspector #138 later spoke with RN #112 who also stated that the bed rails for resident #017 are considered a PASD and are used by the resident to assist with transferring in and out of bed with the assistance of a staff member. RN #112 also added that the resident would not be able to release the bed rails.

Inspector #138 reviewed the plan of care, as defined by the home which includes the electronic care plan, for resident #017 and was not able to find any documentation in the plan of care related to the use of bed rails. Inspector #138 reviewed the plan of care, including the electronic care plan, with RN #112 and RN #112 was not able to locate any documentation regarding the use of bed rails .

Inspector #138 spoke with RPN #113, who is currently working to update the electronic care plans. RPN #113 stated to the inspector that the use of the bed rails as a PASD should be captured in the electronic care plan.

As such, the licensee failed to enure that the use of bed rails as a PASD for resident #017 is included in the resident's plan of care. [s. 33. (3)]

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Issued on this 24th day of October, 2017

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

Original report signed by the inspector.