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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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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 6, 2013 | 2013_128138_0021 | O-000265-13 | Complaint |

**Licensee/Titulaire de permis**

~~NEW ORCHARD LODGE LIMITED~~ Extendicare Canada
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)

**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): May 16 and 17, 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, Registered Dietitian (RD), registered nurses (RN), personal support workers (PSW), and a food service worker (FSW).**

**During the course of the inspection, the inspector(s) reviewed several resident's health care record, observed a partial meal service, reviewed the home's therapeutic menus and supportive documents, reviewed policies related to skin care and fall management.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**

**Falls Prevention**

**Nutrition and Hydration**

**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.)<br><br>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.<br><br>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. (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 comply with LTCHA, 2007 S.O 2007, c.8, s. 6. (5) in that the licensee failed to ensure that a resident's substitute decision maker had been given the opportunity to participate fully in the development and implementation of the resident's plan of care with respect to the administration of medications.

A resident was admitted to the home as a short stay resident. The admission note entered into the resident's health care record listed his/her medications as Tylenol and Imodium and the admission orders for medication were also for Tylenol and Imodium. The resident's Substitute Decision Maker (SDM) stated to LTCH Inspector #138 that on the resident's admission s/he gave consent to the home to provide the resident with both Tylenol and Imodium and also Tamiflu and skin treatments if necessary. S/He also stated to LTCH Inspector #138 that s/he did not give consent to the home to provide the resident with any other medications and was upset to learn that the resident had been given a dose of Trazadone while s/he was staying at the home. The resident's health care record was reviewed and the electronic Medication Administration Record (eMAR) documented that a dose of this medication was provided to the resident. A progress noted was entered into the resident's health care record several hours later stating that the resident had been aggressive and that a dose of Trazodone was provided to the resident. A physician's order for the Trazodone was obtained prior to the administration of the medication. The resident's health care record was further reviewed and no documentation was found to support that the resident's SDM was contacted regarding the home's decision to obtain a physician's order for Trazodone or to provide the resident with a dose of Trazodone. Discussion was held with the Director of Care and she confirmed that the home did not make an attempt to contact the resident's son to discuss the use of Trazodone with the resident. [s. 6. (5)]

2. 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 a resident as specified in the plan.

A resident was admitted to the home as a short stay resident. The resident's SDM stated that on admission s/he directed the home to provide the resident with a vegetarian diet. The home completed an admission assessment on the resident which stated that the resident was to receive a vegetarian diet although s/he could eat chicken. The home's RD attempted to contact the resident's SDM to clarify the details of the diet order but was not successful. Both the RD and the Dietary Manager stated

that they proceeded to provide the resident a vegetarian diet with chicken allowed. When the resident's SDM came to pick the resident up for discharge it was lunch time and s/he stated to LTCH Inspector #138 that s/he was upset to observe that the resident had meat on his/her plate. The SDM specified that s/he had been served a plate that contained slices of vegetables and three slices of different meats. The RN who had been present for the resident's discharged stated to LTCH Inspector #138 that the resident did receive meat at his/her lunch meal on the day of discharged and that this was done by error. The Dietary Manager also stated that she was aware that the resident received meat on his/her plate at the lunch meal service on the day of discharged and confirmed that the meal that would have been served that day was a cold deli plate that would have contained slices of different meats. A food service worker confirmed through the menu that the three types of meat served on the cold deli plate were pastrami, corned beef, and either a chicken of turkey cold cut. [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 a resident's SDM is involved in decisions regarding the implementation of medications and also to ensure that residents' nutritional care plan is provided as plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg 79/10 s. 50 (2) (b) (i) in that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff of the home, using a clinically appropriate assessment instrument that is specifically designed for skin and wound.

A resident was discharged from the home after a planned short stay. The resident's SDM told LTCH Inspector #138 that once s/he got the resident home s/he noticed a large, yellow, and old looking bruise on the resident's arm that he had not been made aware of. Photos of the bruising were taken by the SDM for documentation and these photos clearly showed that the resident had a large, old looking bruise of his/her forearm. The home's Director of Care was interviewed and she stated that the resident was admitted to the home with no bruising which was further demonstrated in the resident's head to toe assessment conducted on admission. Despite the photos taken by the SDM showing bruising to the resident's forearm, the resident's health record including progress notes and electronic flow sheets for bathing and daily skin observation lacked documentation to demonstrate that bruising of the resident's arm had occurred while in the home nor was there any documentation to show that a skin assessment relating to the bruising was completed by the home's registered nursing staff. [s. 50. (2) (b) (i)]

***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 changes in resident's skin integrity related to bruising is documented according to the home's policy/current practice and any changes in skin integrity are assessed by the home's registered nursing staff, to be implemented voluntarily.***

**Issued on this 10th day of June, 2013**

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

Paula MacDonald RD #138