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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2015	2015_288549_0004	O-001542-15, O-001560-15	Complaint

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

RENA BOWEN (549)

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): January 28 and 29, 2015

During the course of the inspection, the inspector(s) spoke with a specific resident, several Personal Support Workers, a Registered Practical Nurse, a Registered Nurse, the Assistant Director of Care, the Director of Care and the Administrator. The inspector reviewed several resident's health care files, the home's protocol for acquiring medications after hours, the home's protocol for contacting on call MD's after hours, the Registered Nurses staffing schedule for the period of December 4, 2014 to January 16, 2015 and the home's Pharmacy Service Agreement.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times unless there is an allowable exception as defined/described in section 45.(1) and 45.1 of the regulation.

The Registered Nursing schedule for the period of December 4, 2014 to January 16, 2015 was reviewed by Inspector #549. It was noted on the schedule that there was no Registered Nurse on duty and present in the home on the evening shift of December 4, 2014, the night shift of December 5, 2014 or the night shift of January 16, 2015.

It was confirmed with the Director of Care and the staffing clerk that there was no Registered Nurse on duty and present in the home on the evening shift of December 4, 2014 the night shift of December 5, 2014, and the night shift of January 16, 2015.

Extendicare West End Villa is a 240 bed long term care home. The allowable exceptions to the requirement as defined/described in section 45.(1) and 45.1 are not applicable. [s. 8. (3)]

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 there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The licensee is required under Reg.79/10 s. 114 (2) to have written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction of all drugs in the home.

The home has a written protocol for acquiring medications after hours. Inspector #549 observed that each of the nursing stations in the home has the written protocol for acquiring medications after hours available for the registered nursing staff.

The after hours and urgent protocol for acquiring medications is as follows: The protocol for urgent orders only when Medical Pharmacy is closed and medication is not in Emergency Starter Box. Loblaws is to be called during the following hours Monday to Friday between 9am-9pm, Saturday between 9am and 6pm and Sunday between 10am and 6pm. Medical Pharmacy – emergency cell number is to be called outside of the above hours.

Inspector #549 reviewed Resident #2's progress notes for a specific time period.

Resident #2's progress notes for a specific date stated Resident #2 "returned from the hospital unresponsive. RN confirmed orders with DR. on Call and updated Care Plan".

The Physician's Orders form for Resident #2 indicate a narcotic prn for pain.

Resident #2's progress notes on a specific date indicate that the resident's family

requested that Resident #2 receive a dose of the narcotic as the family felt the resident was in pain.

Resident #2's progress notes on a specific date indicate that RPN S#104 was called to Resident #2's unit "to attend to an emergency situation". RPN S#104's notes state that Resident #2's "family was making demands" for the narcotic for their mother" and that "all efforts to obtain the narcotic proved unsuccessful as there was none found in the entire facility".

During a telephone interview with Inspector #549 on January 29, 2015, RPN S#104 indicated that he called the Emergency Pharmacy-Loblaws phone number twice and did not receive a call back. RPN #104 confirmed that he did not call the Medical Pharmacy-emergency cell number as per the protocol.

During an interview with the Director of Care on January 29, 2015, it was confirmed to Inspector #549 that RPN S#104 did not call the Medical Pharmacy- emergency cell as per the home's protocol.

The resident's progress notes state that Resident #2's family called 911 to have the resident sent back to hospital to receive the narcotic as the home was not able to provide it to the resident. [s. 8. (1) (b)]

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 any plan, protocol, procedure, strategy or system instituted or other wise put in place is complied with specifically the protocol for contacting the pharmacy after hours, to be implemented voluntarily.

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.