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 16, 2016	2016_288549_0004	020719-15	Complaint

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 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 20, 21 ,22, 2016

This Complaint Inspection is related to a complaint regarding nursing and personal care, missing personal items, administration of medication and nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse, the Food Services Supervisor (FSS), the Food Services Manager (FSM), the Registered Dietitian (RD), the Support Services Manager, the Assistant Director of Care, the Director of Care and the Administrator.

The inspector also reviewed a residents health care file including the Daily Food and Fluid Intake sheets, the Daily Care Flow sheets and the home's Finding Missing Personal Clothing policy # HL-06-03-12 updated September 2015, the home's complaint/concern process and observed two medication administration passes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's response to interventions is documented.

O.Reg.79/10 s.32 (hygiene care and grooming) and s. 33 (baths) require care needs to be documented.

Resident #001 was admitted to the home in March 2006. The Minimum Data Set(MDS) assessment dated on a specific date in March 2014 indicates that the resident's cognitive skill for daily decision-making is moderately impaired.

Inspector #549 reviewed resident #001's written care plan with a last reviewed date on a specific date in April 2014 which indicated that the resident was to have a shower twice a week.

The Director of Care (DOC) indicated to Inspector #549 on January 21, 2016, the practice of the home in 2014 was for the PSW's to document on the resident's daily care flow sheet indicating that the resident received their bath or shower or refused their bath or shower on the scheduled day of the bath or shower. If the bath or shower is given on an alternate day the practice of the home is for the PSW's to document on the resident's daily care flow sheet indicating the bath or shower was given on an alternate day.

Inspector #549 reviewed resident #001's daily care flow sheets for a specific period in 2014. During this time period resident #001 was scheduled for thirty showers. The resident's daily care flow sheets have no entry for nineteen of the thirty scheduled showers for specific period in 2014. There is one entry for a specific date in March 2014 that the resident refused a shower. There is no entry indicating that the resident received a shower on an alternate day. Inspector #549 reviewed resident #001's progress notes for the same time period and was unable to locate any documentation indicating that the resident refused a shower or had received a shower on an alternate day.

Inspector #549 reviewed resident #001's daily flow sheets for a specific period in 2014. During this time period there were thirty five specific days where there is no documentation indicating that resident #001 had been shaved. There are no entries indicating that the resident refused to be shaved. Inspector #549 reviewed resident #001's progress notes for the same period of time and was unable to locate any entry indicating that the resident refused to be shaved.

During an interview with the DOC and the Assistant Director of Care (ADOC) on January

21, 2016, it was indicated to Inspector #549 that the home's expectation is that the PSWs document on the resident's daily care flow sheet when the resident was given a shower or bath, refused a shower or bath or had a shower or bath on an alternate day. The DOC also indicated that the expectation is that the PSWs document on the resident's daily care flow sheets when the resident was shaved or refused to be shaved.

2. O. Reg. 79/10 s. 68. (2) (d) requires the home to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Inspector #549 reviewed resident #001's written plan of care last revised on a specific date in April 2014. The written plan of care indicated that staff are to bring the resident to meals, set up the meal and monitor intake.

During an interview on January 21, 2016, the Food Services Supervisor (FSS) indicated to Inspector #549 that the home's food and fluid intake monitoring and evaluating system includes daily documentation of food and fluid intake for each resident on the Resident Daily Food and Fluid Intake sheets.

The FSS, the Registered Dietitian and the ADOC indicated to the inspector that it is the responsibility of the Personal Support Worker to complete the Food and Fluid Intake form for their assigned residents.

Inspector #549 reviewed resident #001's Daily Food and Fluid Intake sheets for a specific period in 2014. The home was unable to locate the Daily Food and Fluid Intake sheet for a specific month in 2014.

The Daily Food and Fluid Intake sheets indicated during a specific month in 2014 that the afternoon nourishment had no entries on twenty six specific days. The evening nourishment had no entries on seven specific days. There were no entries for breakfast and lunch on two specific days.

During a different specific month in 2014 the Daily Food and Fluid Intake sheets had no entry for breakfast and lunch on four specific days. There were no entries for the morning nourishment on nine specific days. There were no entries for the afternoon nourishment on seven specific days.

During another specific month in 2014 the Daily Food and Fluid Intake sheets had no

entries for breakfast on five specific days. There were no afternoon nourishment entries on twenty three specific days. There are no entries for the dinner meal on ten specific days.

There were sixty one residents on the fifth floor. The FSM reviewed all the resident's Food and Fluid Intake sheets with Inspector #549 on the fifth floor for a specific month in 2016. It was observed by the FSM and the inspector that there were fifteen residents that had no entry in their Food and Fluid Intake sheets for breakfast, lunch and morning nourishment on a specific date in the specific month in 2016.

There were sixteen residents that had no entry in their Food and Fluid Intake sheets for breakfast, lunch and morning nourishment on two specific dates in 2016. There were twelve residents that had no entry on their Food and Fluid Intake sheets for breakfast, lunch and morning nourishment on a different specific date in 2016.

The DOC and the ADOC indicated to Inspector #549 on January 21, 2016, that the home's expectation is that all residents will have their daily food and fluid intake amount documented on the Resident Daily Food and Fluid Intake sheet each day. The expected documentation will also include if the resident refuses, is sleeping, in hospital or on a leave of absence. [s. 30. (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 shall ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented, to be implemented voluntarily.

Issued on this 16th day of February, 2016

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

Original report signed by the inspector.