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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2016	2016_289550_0021	012099-16, 013065-16	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

JOANNE HENRIE (550)

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): June 16 and 17, 2016

This inspection is related to 2 complaints; log #012099-16 is regarding financial abuse and personal care services and log #013065-16 is regarding plan of care, continence issues and staffing.

During the course of the inspection, the inspector(s) spoke with the home's Assistant Director of Care (A-DOC), the MDS/RAI Coordinator, Registered Nurses, Registered Practical Nurses, a Social Worker, Personal Support Workers (PSW), residents and a family member.

In addition, the inspector reviewed residents health care records and the home's staffing plan. The inspector also observed resident care and services and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #001 was admitted to the home on a specific date in January 2016 with multiple diagnoses. During an interview, resident #001 indicated to Inspector #550 that he/she was receiving two different pain medication, two different medication because of side effects from the administration of the pain medication and vitamins which the resident no longer needed. The resident indicated he/she mentioned this to staff a while ago but so far nothing had been done about this and he/she was still given these medications on a daily basis. Resident #001 told the inspector he/she was prescribed pain medication for fractures he/she sustained in 2015. Resident #001 further indicated to the inspector that he/she no longer needed the pain medication because for a period of five days he/she would spit out and throw away these medications after the nurse gave them to him/her and he/she did not experience any pain for those five days.

It was documented in the physician's orders and the medication administration record that the resident was prescribed and administered the following medications:
-a specific vitamin supplement monthly
-a specific combination of vitamins by mouth daily
-a specific pain medication by mouth at bedtime
-a specific pain medication by mouth each morning
-a specific combination of vitamins by mouth daily
-a specific laxative by mouth at bedtime
-a specific vitamin by mouth daily
-a stool softener by mouth twice daily
-a specific pain medication by mouth four times daily

Progress notes were reviewed and it was documented by RPN staff #S100 on April 26, 2016:
"Was asked to talk to the resident regarding his/her medication. Went looking for resident #001 Thursday and Friday X 2 unable to connect with him/her. Talked to resident #001 today. Showed resident #001a list of his/her medications and went thru them each one. States he/she does not have any more pain stated that he/she was in bad shape when they put him/her on all the pain medication. Wants it stopped will inform MD., convinced resident #001 to stay on a specific pain medication QID and he/she has agreed to this.

Informed the resident that his medication has remained the same since admission."

Physician's orders:
April 29, 2016: Please have pharmacy review medication for suggestion of reducing some medication.
April 30, 2016: Pharmacy to review meds.

During an interview, the A-DOC indicated to the inspector the resident's medications were not reassessed after his request to have the pain medication discontinued.

As such, resident #001 was not reassessed and his/her plan of care was not revised when his/her care needs changed (log # 012099-16). [s. 6. (10) (b)]

2. Resident #002 was admitted to the home on a specific date in February 2016 with multiple diagnoses including dementia and leg pain. During an interview, resident #002 indicated to the inspector that upon admission he/she was able to use the commode for toileting issues but now he/she is no longer able to transfer on the commode as the resident is no longer able to bear weight and has chronic pain in a specific lower body part. Resident #002 indicated he/she sometimes is able to use the bedpan but he/she is often incontinent.

A review of the resident's health care records indicated resident #002 is frequently incontinent of urine and sometimes of feces and wears an incontinent product.

During an interview, PSW #S101 indicated to the inspector the resident rarely uses the commode anymore as he/she has too much pain in specific lower body parts will use the bedpan when requested. Resident #002 is often incontinent of urine and staff have to verify and change the resident's incontinence product as well as provide incontinence care.

Inspector reviewed the resident's care plan dated a specific date in June 2016 and noted there was no provision for continence care.

During an interview and a review of the resident's care plan, the RAI Coordinator indicated to the inspector the resident's plan of care was not revised when resident #002 became frequently incontinent.

As evidenced above, resident #002 was not reassessed and his/her plan of care was not

revised when his/her care needs changed (log #013065-16). [s. 6. (10) (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 resident #001 and 002's plan of care are reassessed when the residents' care needs changes or when the care set out in the plan is no longer necessary,, to be implemented voluntarily.

Issued on this 20th day of June, 2016

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

Original report signed by the inspector.