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 sions 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
Oct 21, 2016	2016_287548_0027	029903-16	Critical Incident System

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

RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 18 and 19, 2016

The inspection included one critical incident related to alleged neglect of care.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Wound Care Champion, Enterostomal Therapy Nurse (ET nurse), Registered Nurse and Registered Practical Nurses.

The inspector also observed a dressing change, reviewed the resident's health care record, documents associated with the home's investigations related to the alleged incident and reviewed the home's policies related to skin and wound care management.

The following Inspection Protocols were used during this inspection:
Skin and Wound Care

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. 6. Plan of care

Specifically failed to comply with the following:

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 ensure the care set out in the plan of care was provided to the resident as specified in the plan.

Related to Log#: 029903-16

As per O.Reg. 79/10, Neglect is defined as: " means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical incident report was submitted to the MOHLTC on a specified day in October 2016 related to an alleged incident of neglect of care. A registered practical nurse #104 identified changes in a wound status when completing a dressing change.

The resident presents with a wound ulceration to a specific body part due to medical diagnoses and is followed by an interdisciplinary team for specific treatments. The wound was identified on a specified date in February 2016.

Inspector #548 reviewed the health care record specific to the resident's wound.

Resident's #001 Minimum Data Set MDS assessment completed on a specified date in August 2016 indicated that resident's ulcer to a specific body part remains unresolved due to the resident's medical status. On a specific day in September 2016 the wound treatment was changed by the wound care champion #101,with specific instructions to change the dressing twice a week and when necessary.

A progress noted entry dated for a specified day in October 2016 indicated that the resident's #001 wound appeared to be uninfected and to continue with the same dressing protocols. Several days later a progress note entry on a specified day in October 2016 indicated that the registered nursing staff member #104 informed the charge nurse that the wound dressing had a foul smell with exudate.

The home's policy directs registered nursing staff to perform treatment and dressing changes as per treatment orders- Skin and Wound Program: Prevention of Skin Breakdown, #RC-06-12-01, Dated: July 2016.

On the Treatment Administration Record (TAR) dated for October 2016 the resident's treatment plan specified the dressing to be changed twice weekly and when necessary. It is noted that on a specified day in October 2016 the resident refused the treatment.

On October 18, 2016 during interviews with the home's wound care champion #101 and RPN #100 both indicated that although the resident will at times refuse a dressing

change, nursing staff are responsible to communicate the refusal and the resident is to be re-approached.

On October 20, 2016 during an interview RPN #102, who was working on a specified day in October 2016, indicated that she approached the resident twice to complete the dressing change however, does not recall if she communicated the resident's refusal of the treatment to the other registered nursing staff. At the time of the inspection it was inconclusive as to how the wound status changed.

The licensee failed to provide wound care treatment as identified in the resident's plan of care. [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 ensure resident's exhibiting altered skin integrity are provided the care as specified in the plan, to be implemented voluntarily.

Issued on this 21st day of October, 2016

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

Original report signed by the inspector.