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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 16, 2018	2018_702197_0018	028579-17, 000835-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

JESSICA PATTISON (197)

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): August 13, 14, 16, 17 and September 4, 2018

The following intakes were completed as part of this inspection:
log 028579-17 - related to multiple concerns about resident care including bathing, foot care and diabetic care
log 000835-18 - related to allegations of resident abuse, missing personal items, responsive behaviours, supplies and bathing

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Clinical Care Coordinator, the office manager, the Dietary Manager, a Registered Practical Nurse, a Personal Support Worker and residents.

The inspector also reviewed resident health care records, internal investigation files, the WEV concern form, the Complaints and Customer Service Policy, documents related to foot care and also observed resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

On a specified date, the physician ordered insulin and blood glucose monitoring for 1 week, twice daily for resident #001.

Two blood glucose readings were taken on the first day and one on the 2nd day in the morning and then no more until 12 days later.

On a specified date, a progress note was written by RPN #106 indicating that resident #001 had returned to the home with their family who inquired about the resident's blood glucose readings that the Physician had ordered the week prior. The RPN noted that there appeared to be a mistake because the order was made on a particular day, but then it ended the day after in the morning. The RPN noted that they would follow-up to see who transcribed the order to the medication administration record (MAR).

During an interview with Clinical Care Coordinator #104, they indicated that the second part of the order, to monitor BG levels, was missed. They said there should be two checks/signatures on orders as a double check, but there was only one signature on this

particular order. They further stated that it was their understanding that pharmacy only puts in medication orders and that nursing would have to put in any orders pertaining to care/procedures.

Resident #001's blood glucose levels were not checked as ordered by the Physician and therefore, the resident did not receive the care that was specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that a provision of care set out in resident #001's plan of care with respect to bathing was documented.

Resident #001's plan of care related to bathing indicated that the resident was to have two showers/baths per week.

The daily care flow sheets for resident #001 were reviewed for the period of time the resident resided in the home. During this time, it was noted that 19 scheduled showers/baths for resident #001 were not documented as being completed. [s. 6. (9) 1.]

3. The licensee has failed to ensure that resident #001 was reassessed and their plan of care reviewed and revised when care set out in the plan was not effective.

Blood glucose readings for resident #001 were reviewed and it was noted that the readings began to increase in a particular month with multiple readings over 15.0 mmol/L and some reaching over 20.0 mmol/L.

On a particular date, resident #001's health care record indicated three high blood glucose readings.

On this date, two progress notes were made. One by the resident's physician and the other by an RPN. Neither one indicated the resident was having high blood glucose levels.

The next blood glucose reading after the three high readings noted above was documented approximately 2 weeks later by RPN #100 in the progress notes and was again noted to be high. The progress note indicated that the resident was complaining of a headache and received medication on request. There was no documented follow-up or assessment related to the high blood glucose reading.

On a later specified date, resident #001 was out of the home. The resident's Power of Attorney (POA) for care indicated to the inspector that while the resident was out of the home, their blood glucose was taken and the POA was told it was high. The POA then asked nursing staff at the home what the resident's BG reading was earlier that day and was informed that it had not been taken and that blood glucose readings had been discontinued by the Physician approximately three week prior.

The inspector confirmed that an order was written by the physician on the specified date to discontinue glucometer checks.

Blood glucose monitoring resumed and resident #001's blood glucose was noted by RN #101 to be high and the progress notes indicated that they had written the high blood glucose reading in the MD communication book and noted on the calendar to contact the physician the following day.

The next day, resident #001's blood glucose was noted to be high in the progress notes but there was no documented follow-up and no call to the Physician as was indicated the day before.

The next day, RN #102 noted in the progress notes that resident #001's BG was still high and indicated that the day RN was informed to follow-up.

Blood glucose readings continued to be taken over the next 4 days and continued to be high. During this time there were no further progress notes to indicate contact with the Physician or reassessment of the resident related to the high blood glucose levels.

RPN #103 then wrote a progress note indicating that resident #001 had two high blood glucose readings and that the charge nurse was notified.

The Physician was then informed of resident #001's high blood glucose levels and an order was given to start them on medication. The next day, the Physician met with the resident's family to discuss the resident's care related to the management of the high blood glucose levels.

Clinical Care Coordinator (CCC) #104 was interviewed related to resident #001's blood glucose monitoring and staff actions. When resident #001 was first admitted to the home they were put on medication to manage blood glucose levels but it was discontinued soon after. CCC #104 indicated that the staff that discontinued the insulin should have

looked back at the resident's admission records and consulted the RN before calling the Physician to have the medication discontinued. The CCC stated that communication from the evening RNs to the day RNs and the follow-up had been an issue. Evening/Night RN's are to make non-emergent notes in the communications calendar for the day RN to follow-up on. There were three notes made on three different days in the communication book related to resident #001's high blood glucose levels. CCC #104 indicated that the Physician should have been contacted after the first note was made.

Resident #001 started to experience multiple abnormally high blood glucose levels. These high blood glucose levels persisted, yet the Physician was not notified and glucometer checks were ordered to be discontinued. The POA for care of resident #001 was informed that the resident had high blood glucose when outside the home and once back at the home, nursing staff resumed blood glucose readings. The blood glucose readings remained high, yet no action was taken until just over 1 week later.

Resident #001 was not reassessed and their plan of care was not reviewed and revised when care set out in the plan was not effective. [s. 6. (10) (c)]

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 the care set out in the plan of care is provided as specified in the plan, that provisions of care set out in residents' care plans are documented and that residents are reassessed and their plans of care reviewed and revised when care set out in the plan has not been effective,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 receives preventative and basic foot care services, including cutting of toenails, to ensure comfort and prevent infection.

Upon admission of resident #001 to the home, their POA for care did not sign the foot care agreement in the admission package and indicated that they were not informed that they needed to sign this agreement in order for the resident to receive foot care.

The resident's plan of care stated the following dated at the time of admission:

"DO NOT CUT TOE NAILS..."

During an interview with the Administrator, they indicated that the nursing staff in the home do not provide foot care (including trimming of toenails) to residents with a specified diagnosis, as they do not have the training to do so. The Administrator further indicated that the home contracts a foot care nurse and this is an additional cost to the residents. They indicated that the foot care agreement needs to be signed in order for the foot care nurse to provide the service. The Administrator indicated that when the foot care nurse provides care, they will document the care in the progress notes.

A review of resident #001's progress notes showed no notes by the foot care nurse to indicate the resident had received foot care.

On September 10, 2017, a note by RPN #100 indicated that the POA for care of resident #001 was concerned about foot care because the resident's nails were long and they needed foot care to be done. The note further indicated the resident has a certain diagnosis and that they were added to the foot care nurse list to be completed on a specified date.

The foot care schedule for the specified date above was reviewed and it was noted that resident #001 was not signed as having received foot care. During an interview, the Administrator indicated that resident #001 would not have received foot care due to the fact that the POA for care of the resident had not signed the foot care agreement at that time.

At a later date, RN #105 documented that resident #001's family requested nails on fingers and toes to be done. The RN documented that they went to see the resident's

nails and noted that they need to be done and that they added resident to the list for the foot care nurse. The foot care nurse was called as they were to come to the home that day, but indicated to the RN that due to the outbreak they would not be in to provide foot care to residents that day.

Later on that same day, the Director of Care (DOC) documented that they called resident #001's family to discuss foot care and at this time the family indicated they would cut the resident's nails and indicated that the family had also cut the resident's nails on another date.

The home failed to provide preventative and basic foot care services, including the cutting of toenails, to resident #001. [s. 35. (1)]

Issued on this 15th day of November, 2018

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

Original report signed by the inspector.