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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2013	2013_230134_0021	O-000937-13, O-000966-13	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

COLETTE ASSELIN (134)

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): November 26, 27 and 29, 2013

Two complaint inspections log # O-000937-13 and # O-000966-13 were conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurse, the Pharmacist, Personal Support Workers (PSW), family members and Resident #1.

During the course of the inspection, the inspector(s) reviewed the Residents' Health Care records, Resident #1's Medical Pharmacies' Customer Transaction Report.

The following Inspection Protocols were used during this inspection:
Admission Process

Dignity, Choice and Privacy

Falls Prevention

Medication

Pain

Personal Support Services

Resident Charges

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, Chapter 8 s. 6 (11) (b), in that the home failed to consider different approaches to manage Resident #1's skin condition when the care set out in the plan was not effective.

The progress notes were reviewed between specified dates in August and September 2013. There are several entries in the progress notes indicating the resident's ulcer dressing was soaking wet and foul smelling. These observations were noted 11 times in one month.

Resident #1's wounds were changing significantly in that period. As per documentation in the health record, the resident complained of having more pain and was showing signs of agitation and required analgesics more frequently.

Based on the Treatment Administration Record (TAR), the dressing to the wound was to be done once a week. There was no change to this order even though the resident's wound had more discharge and was foul smelling. No referral to the ET nurse was made. The ongoing antibiotic therapy did not appear to help manage the foul smell and heavy discharge from the resident's wound.

There is a chart entry on a specified date in August 2013 indicating the resident's SDM expressed concerns about the resident's dressing being wet again. There is another entry in September 2013 indicating the resident's SDM was very upset about the dressing being soaking wet and smelly.

The in-house wound nurse was interviewed December 6, 2013 and indicated his/her role was to assess the resident's wound once a month and that the registered staff on the unit was responsible to change the dressing. He/she indicated an antimicrobial dressing was ordered on a specified date in August 2013 and a different dressing was ordered on a specified date in September 2013.

The resident was sent to hospital for assessment and wound care treatment on a specified date in September 2013 and was returned to the home on a specified date in October 2013,

As such, the licensee failed to consider different approaches in the revision of the plan of care when the care set out in the plan was not effective. [s. 6. (11) (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 new approaches are considered when the care set out in Resident #1's plan of care is not effective in managing wound care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg section 134 (a), in that while Resident #2 was taking a combination of drugs, there was no monitoring and documentation of the resident's response and the effectiveness of the drug as appropriate to the risk level of the drugs.

Upon admission on a specified date in January 2013, Resident #2 was ordered a medication intramuscular (IM) or by mouth as needed. This medication is not covered under the Ontario Drug Benefit and is to be given for nausea and vomiting.

The Medication Administration Record (MARS) was reviewed for January and February 2013. It is to be noted that this medication was ordered prn for nausea and vomiting but was not administered for those symptoms, Gravol 50 mg was given as needed for daily bouts of nausea and vomiting between January 2013 and February 2013.

A new order for this medication to be administered po or IM was received on a specified date in February 2013 for ongoing nausea and vomiting. The order is also to continue with the PRN order.

Based on the progress notes Resident #2 continued to have nausea and vomiting almost daily between a specified date in February until mid-March, 2013, even though the anti-emetic drug was administered every 8 hours.

The SDM, who visited the resident daily was interviewed November 26, 2013 and indicated that the resident had no nausea in March 2013 and on onward. According to the resident's SDM the resident was known to have recurrent bladder infection which caused nausea and vomiting. The SDM reported that when the resident was on antibiotic therapy for UTI, the nausea and vomiting subsided.

It is to be noted that on a specified date in March 2013, an order was received for antibiotic therapy for a urinary tract infection (UTI). This order seemed to have coincided with the management of the resident's symptoms of nausea and vomiting. There is no documented indication in the progress notes to link the cessation of vomiting with the antibiotic therapy, which was continued till the end of August 2013. There is no documented monitoring of the effects of this anti-emetic drug, which was not covered by ODB.

As such, the effectiveness of the anti-emetic drug given every 8 hours and the antibiotic medication was not monitored or documented once the resident's vomiting stopped in March 2013. [s. 134. (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

 i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

 ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The Licensee failed to comply with the O. Reg 79/10 section 245 (4), in that consent was not provided for medication that was not covered by the Ontario Drug Benefit.

Resident #2's signed "Purchase Of Services Agreement" was reviewed by the inspector. There is an entry on page 3 indicating the following: "The resident is responsible for paying charges and co-payments for good and services that are not covered or funded under the Government programs, such as the Ontario Drug Benefit Plan, or the Ontario Health Insurance Plan, These goods and services include certain drugs, treatments, devices and transport".

The progress notes were reviewed and there is no documented evidence that the Substitute Decision Maker (SDM) provided consent for paying the anti-emetic drug at the time of Resident #2's admission on a specified date in January 2013 or on a specified date in February 2013 when the medication was ordered to be administered every 8 hours on a daily basis.

The Medication Administration Records were reviewed and there are several conflicting signatures indicating the IM and oral anti-emetic medication were administered at the same time. It is difficult to determine how many times the resident received the intramuscular anti-emetic medication versus the oral anti-emetic medication.

The SDM received an invoice from the Medical Pharmacies indicating Resident #2 was charged for the anti-emetic drug administered every eight hours for a 6-month period, that he/she was not aware he/she had provided consent for.

The "Pharmacy's Communication Sheet" was reviewed and there is no signature or discussion note indicating the SDM was aware that the anti-emetic was not covered by ODB and there is no indication that approval for the cost of the oral and intramuscular anti-emetic drug was given. [s. 245. 4.]

Issued on this 11th day of December, 2013

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

Colette Asseli, LTCH Inspector # 134