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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Licensee Copy/Copie du titulaire de permis

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Jul 23, 2014	2014_198117_0019	O-000442-14 & 3 OTHER LOGS	Complaint

Licensee/Titulaire de permis

~~NEW ORCHARD LODGE LIMITED~~ 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

LYNE DUCHESNE (117)

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): July 10, 11, 14, 15 and16, 2014

It is noted that four (4) complaint inspections were conducted during this inspection : Logs # O-000442-14, #O-000488-14, #O-000575-14 and #O-000632-14.

PLEASE NOTE: The following non-compliance was identified

Non-compliance with O.Reg. 79/10 s. 8 (1) (b) Policies, etc ..., to be complied with related to the administration and documentation of medication, was issued in Inspection #2014-286547-0018, conducted on July 10, 11, 14, 15, 16, 17, 18, 21 and 22 2014 and is contained within the Report of that Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian, Food Service Supervisor, several Registered Nurses (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several activity staff members, Manager of Activity and Recreology, dietary aides, a Physiotherapist, physiotherapy aide, Support Services Manager, housekeeping aide, and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several residents; observed provision of resident care and services; observed the lunch time meal services of July 10, 15 and 16 2014; examined medication carts; observed resident care unit hallways and resident rooms; observed resident care activities on the 4-5th floor resident care units, in the main activity room and outside gardens; reviewed activity calendars for 2013 and 2014; reviewed 5th floor unit maintenance logs for 2013-2014; reviewed staffing schedule for July 2014; reviewed infection control protocols; reviewed physiotherapy provision of care reports; reviewed Pharmacy Policy #3-6 "The Medication System: The Medication Pass", revised January 2014; and the home's complaint and response process.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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 failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 6 (9) (1) in that the licensee did not ensure that the following are documented: the provision of care set out in the plan of care.

[Log #O-000488-14]

Resident #1's plan of care identifies that the resident is at moderate nutritional risk. The resident is on a regular diet with regular texture. The plan of care identifies Resident #1 as being at risk of refusing to eat and requires encouragement to eat in the unit dining room. Resident #1 is noted to have occasional abdominal pains impacting his eating habits. On May 18, 2014 Resident #1 was placed on a "soft, no meat" diet in anticipation of an endoscopy test conducted on June 9, 2014. Post-test, Resident #1 resumed a regular texture, regular diet.

A review of the resident's food and fluid intake records for May, June and July 2014 was conducted. It was noted that the food and fluid intake records are incomplete, with regularly missing information on Resident #1's breakfast food intake and occasionally for Resident #1's lunch and supper food and fluid intake. Resident #1 was observed by Inspector #117 to be eating well at the breakfast and lunch time meal services of July 10, 15 and 16 2014.

On July 15, 2014, the home's Registered Dietitian and unit RN S#101 stated to Inspector #117 that dietary and nursing staff are aware of Resident #1's dietary needs and his frequent meal refusal. They report that staff are to be documenting the resident's food and fluid intake or his refusal to eat, as Resident #1 is identified as being at moderate nutritional risk. They both report that there have been issues with staff not consistently documenting Resident #1's food intake and or refusal to eat, and this impacts the ability to assess Resident #1's ongoing nutritional needs. [s. 6. (9) 1.]

2. The licensee failed to comply with LTCHA 2007, S.O.2007, c.8, s. 6 (9) (3) in that the following was not documented: the effectiveness of the plan of care. [Log #O-000488-14 and Log #O-000632 -14]

Resident #1's plan of care identifies that should the resident have occasional pain, Resident #1 has a medical order for Tylenol 325 mg 1-2 tabs po q6h PRN.

On November 28, 2013, Resident #1 expressed to have pain to his right flank. Tylenol 325 mg 2 tabs po was given at 08:42am for pain as per PRN (as needed) medical order. Progress notes document the resident's positive response and decreased pain post medication administration.

On November 29, 2013, Resident #1 complained of pain to his lower back. Tylenol 325 mg 2 tabs po was given at 06:56am as per PRN medical order. No other information related to the resident's pain or response to the medication is noted in his health care record.

On November 30, 2013, Resident #1 complained of severe right flank pain irradiating to the lower back at approximately 13:30pm. Progress notes document that the resident's family was present. That the resident was assessed, noted to have severe pain with elevated blood pressure. An ambulance was called to have Resident #1 transferred to hospital for further assessment.

On December 1, 2013, Resident #1 returned to the home with a diagnosis of a fractured rib. Pain assessment flow sheet was initiated by nursing staff and documents that the resident had no expressed complaints of pain until December 2, 2013 at 00:35am. Tylenol 650mg po prn for pain was given with good effect. The resident received another dose of Tylenol 650mg po prn at 10:38

with good effect.

On December 3, 2013, the resident's attending physician assessed Resident #1 and prescribed Tylenol 650 mg po QID (4 times per day) to be administered for 1 week. As per the Medication Administration Record (MAR) for December 2013, this medication was given to Resident #1 as per medical orders. However, no information related to the resident's condition and effectiveness of the medication was found in Resident #1's health care record.

On July 16, 2014, the 4th floor unit RN S#101 and RPN S#108 , who were not working with the resident on 2nd floor at time of Resident #1's injury and pain management interventions in December 2013, stated to Inspector #117 that nursing staff are to document when PRN and short term medication interventions are given. They report that registered nursing staff is to document the effectiveness of the pain medication in the resident's health care record. The home's DOC also confirmed with Inspector #117 on July 16, 2014, that registered nursing staff are to assess and document residents' responses to pain medication. The DOC could not explain why there was no documentation of the monitoring of Resident #1's health status and response to pain medication from November 29 2013 to December 10 2013, when the resident was diagnosed with a fractured rib and received short term pain management interventions.

Resident #4's plan of care and medical records indicate that the resident has a PRN order for Tylenol 325 mg 2 tabs po q6h to be given when required.

On June 14 2014, unit 24- hour nursing report documents that Resident #4 was given Tylenol 325 mg 2 tabs po at 05:52am for generalized pain. The administration of this medication was not documented in the resident's progress notes and eMAR, nor was the resident's response and the effectiveness of the medication monitored and documented. [s. 6. (9) 3.]

3. The licensee failed to comply with LTCHA 2007, S.O. 200, c. 8, s. 6 (10) (b) in that the home did not 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. [Log #O-000632-14]

Resident #4 is diagnosed as having end stage congestive heart failure (CHF), aortic stenosis and renal failure. The plan of care identifies that the resident requires 2 staff assistance with personal care, continence care and monitoring of a catheter foley. The resident is also identified as having frequent urinary tract infections.

On June 8 2014, at 05:54am, it was noted that Resident #4 had blood with her bowel movement. The resident was assessed by registered staff and the resident was noted to be hypotensive. The resident's was monitored during the day and noted to still have hypotension.

On June 9 2014, at 05:10am, Resident #4 had blood and mucous stains in her continence brief. The resident was assessed by registered staff and was noted to be hypotensive.

No information related to Resident #4's ongoing monitoring for hypotension, the presence of blood

and any other changes in the resident's health condition were noted in Resident #1's health care record from June 9 to June 17 2014.

On June 14 2014, the 24-hour nursing report notes that at 5:50 am PRN (as needed) Tylenol 325 mg 2 tabs were given for generalized pain. However there is no information related to the administration of the medication neither in the Medication Administration Record nor in the resident's health care record. Nor is there any other information related to the resident's health status and response to the administered medication.

On June 17 2014, progress notes completed by the unit RPN at 14:52pm document that Resident #4 is very lethargic and unresponsive to verbal communication but did seem to follow instructions. It also notes that both of the resident's feet are swollen and that the resident requires intensive assistance during meal time. No other information related to the resident's lethargy, decreased responsiveness, and swollen feet is noted in the resident's chart or the 24-hour nursing report.

On June 18 2014, at approximately 11:30am, Resident #4's daughter visits the home. The daughter expresses concerns related to the resident's lethargy, decreased responsiveness and swollen feet. Upon family request, Resident #4 is assessed by a registered nurse. The attending physician is contacted and notified that Resident #4 is hypotensive with bradycardia. The physician orders that the resident be assessed by the nurse practitioner and that a chest x-ray be done to rule out possible CHF and urine sample to be collected for possible urinary tract infection.

Resident #4 was assessed by the nurse practitioner as being hypotensive with less responsiveness and with physician discussion a decision was made to keep the resident at the LTC home. At 14:01pm, Resident #4's urinary output was 100ml for the day shift. Upon discussion with the resident's family members who were present at the home, a decision was made to transfer the resident to hospital for further assessment. Resident #4 was transferred and admitted to hospital. On June 26 2014, Resident #4 passed away.

On July 16 2014, unit RPN S#104 and PSW S#105 stated to Inspector #117 that they do not recall being informed of any issues related to Resident #4's health. They report that they were not aware of any issues with the presence of blood with bowel movements, of any hypotension issues, of lethargy or decreased responsiveness. Staff member S#104 states that any significant health changes such as the presence of blood, hypotension, lethargy and changes in responsiveness are to be assessed and monitored by registered staff.

On July 16 2014, the Director of Care (DOC) and Assistance Director of Care (ADOC) reviewed the resident's chart with Inspector #117. They stated that when there is a change in a resident's health status, such as the presence of blood, hypotension, lethargy and changes in levels of responsiveness, unit registered staff are to assess and monitor resident's health status. They stated to Inspector #117 that such health issues are to be documented, the resident's plan of care is to be reviewed and revised based on the resident's changing needs, and reported to other nursing staff to ensure continuity of care.

Resident #4's was not reassessed and her plan of care revised from June 9 to June 18 2014 when the resident had 2 episodes blood with bowel movements, hypotension, lethargy, changes in

responsiveness and swelling of the legs. [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 the provision of care, as it relates to Resident #1's food and fluid intake, is documented; to ensure that the effectiveness of prescribed pain medication medication as identified in Resident #1 and #4's plan of care is documented; and that residents presenting with a change of condition be assessed and have their plans of care reviewed and revised, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 129 (1) (a) (ii) in that drugs were not stored in a medication cart that was secure and locked. [Log #O-000488-14]

ON July 10, 2014, at 10:50am, Inspector #117 observed a vial of Vitamin B 12 to be left unattended, on top of a locked medication cart on the 4th floor resident care unit. The RPN S#106 returned to the care after having left the medication cart unattended for several minutes. RPN S#106 stated to Inspector #117 that he was administering monthly Vitamin B 12 injections to several residents as per medical orders and the he had left the vial unattended while administering the prescribed medication to Resident # 6 privately in the resident's room. [s. 129. (1) (a)]

2. On July 15 2014 at 12:40pm, Inspector #117 observed a bottle of TUMS with Calcium 500 mg per tablet on top of a locked medication cart by the 4th floor unit nursing. No registered staff was observed to be close to the medication cart. The unit RPN S#107 was observed to be walking away from the medication cart, and was half way down to the hallway when went into a resident room to administer a medication. Upon return to the medication cart, RPN S#107 stated to Inspector #117, that she forgot to put the medication bottle in the medication cart when she went to administer Resident #7's medication.

On July 10 and 15 2014, registered unit staff left medication on top of a medication cart and did not ensure that medications were stored in a secure and locked medication cart. [s. 129. (1) (a)]

Issued on this 23rd day of July, 2014

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

Lynn Duchesne RN #117