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

Division de la responsabilisation et de la performance du système de santé
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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
Dec 23, 2014	2014_330573_0020	O-001150-14, O-001297-14	Critical Incident System

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

ANANDRAJ NATARAJAN (573)

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): December 3,4 and 5, 2014

The following Critical Incidents were inspected:CI 2709-000087-14(Log #O-001150-14);CI 2709-000096-14 (Log #O-001297-14).

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Physiotherapy Assistant, Registered and Non-Registered Nursing staff and Residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. Licensee failed to report the information as described in subsection (3) ,within 10 days of becoming aware of an alleged, suspected or witnessed incident of abuse , or at an earlier date if required by the Director .O. Reg.79/10,s.104(2)

Related to log O-001150-14

On October 1st, 2014 Resident #001 family member reported concerns to the home Administrator regarding bruising and skin tear on Resident #001. The Administrator confirmed that an internal investigation into alleged abuse was initiated by the home immediately.

The Home Administrator informed Ministry of Health (MOH) – Centralized Intake, Assessment and Triage Team (CIATT) by email on October 1st, 2014 regarding the family member concerns and about the investigation for possible causes for the skin tear and bruising. Furthermore the Administrator indicated in the e-mail that once the investigation is completed the results will be notified by email or will complete a Critical Incident Report (CIR).

On October 9th, 2014 another email was sent to MOH- CIATT by the Administrator stating that following an thorough investigation it was determined that the skin tears and bruising were accidental and as a result, the home will not be filing a Critical Incident Report (CIR) report for this incident.

On October 14th, 2014 12:29 hours a Critical Incident Report (CIR) -2709-000087-14 was submitted to the Ministry of Health and Long Term Care reporting a mandatory report category abuse/neglect at the request of an CIATT Inspector. [s. 104. (2)]

Issued on this 23rd day of December, 2014

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

Original report signed by the inspector.