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 5, 2014	2014_295556_0037	O-001097	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

WENDY PATTERSON (556)

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): December 1, 2, 3, 4, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Behavioural Supports Ontario Lead (BSO), Registered Practical Nurses (RPN), Health Care Aids (HCA), Residents, and Family Member

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported, is immediately investigated.

The LTCHA 2007, c. 8, s. 2 (1) states in this Act, "abuse" in relation to a resident, means physical, sexual, emotional, verbal or financial abuse as defined in the regulations. The Ontario Regulation 79/10, s.2 (1)states for the purposes of the definition of "abuse" in subsection 2 (1) of the Act "physical abuse" means, (c) the use of physical force by a resident that causes physical injury to another resident.

According to a progress note on Resident #001's health care record, on a specified date Resident #001 was found lying on the floor in his/her room and Resident #001 reported that his/her room-mate pushed him/her over when he/she was trying to use the bathroom. The progress note further stated that the on call manager was notified, the Ministry of Health and Long-Term Care (MOHLTC) were notified, the police were called and would be coming to the home to file a report, and Resident #001's Substitute Decision Maker (SDM) was called. A progress note indicated that as a result of the incident Resident #001 sustained a fracture.

A progress note written by the Administrator stated "I discussed with our Admission Supervisor who the room-mate was that was aggressive." "Call to Resident's SDM. I apologized for the incident and explained that the other resident is being moved."

Critical Incident Report (CIR) #2709-000079-14 submitted to the MOHLTC by the home on August 25, 2014 was reviewed and stated that the fall was unwitnessed however Resident #001 stated that his/her room-mate pushed him/her over when he/she was trying to use the bathroom. The CIR further stated that these two residents had been in two previous minor altercations prior to this incident and in both cases the room-mate of Resident #001 was the aggressor.

A letter provided by the ADOC that was sent by the Administrator to the SDM of Resident #001 was reviewed. The letter stated "during our last conversation which occurred on a specified date in response to a voice message you left for me on a specified date, I apologized to you for the incident and explained that the other resident involved in the incident was being moved to another room." "This resident has now been transferred to another floor so there should not be any further risk to your parent from this resident".

As part of the inspection Inspector #556 asked to review the home's documentation of the investigation into the suspected incident of physical abuse of Resident #001 by his/her room-mate and after discussion with the Administrator the ADOC stated that the Administrator regarded the incident as an unwitnessed fall and not a suspected resident to resident abuse and therefore did not complete an investigation into the incident. [s. 23. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

During the course of an inspection two letters of complaint from the Substitute Decision Maker (SDM) of Resident #001 to the Administrator of the home were reviewed. The letters were in regards to an incident that occurred on a specified date. The letters indicated that Resident #001 was pushed over by his/her room-mate which resulted in Resident #001 sustaining a fracture.

The homes policy entitled Complaints, policy #09-04-06 was reviewed and it stated when a written complaint is received the following will occur (d) the Department Manager will initiate an investigation into the complaint, (g) notes will be taken of all interviews, observations and other actions related to the investigation.

As part of the inspection Inspector #556 asked to review the home's documentation of the investigation into the complaint and the Administrator stated that an investigation was not conducted following receipt of the letters of complaint and the only notes available were what was documented in the progress notes.

The progress notes in Resident #001's health care record were reviewed and no notes were located indicating that an investigation was conducted into the incident that occurred on a specified date involving Resident #001 and his/her room-mate. [s. 101. (1) 1.]

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Issued on this 19th day of December, 2014

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

Original report signed by the inspector.