**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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 13, 2016 | 2016_200148_0032 | 028389-16 | Complaint |

**Licensee/Titulaire de permis**

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**

AMANDA NIXON (148)

## 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): September 28, 29 and 30, 2016**

**This inspection included a complaint and associated critical incident report related to an alleged sexual abuse.**

**During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RAI Coordinator, Admissions Supervisor, Staffing Coordinator, Program Manager, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), residents and family members.**

**The Inspector also reviewed resident health care records, discharge letters of an identified resident, documents associated with the home's investigations into the identified alleged abuse incident, staffing schedules and admission assessments.**

**The following Inspection Protocols were used during this inspection:**
**Admission and Discharge**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences

Resident #001 was involved with an alleged sexual abuse incident that was reported to the Director/MOHLTC on a specified date, which occurred in the early morning hours. Concerns arose about the sleep patterns and monitoring of resident #001 when out of bed at night.

Inspector #148 reviewed the resident’s health care record, it was demonstrated that the plan of care did not include aspects of the resident sleep patterns. Assessment information was reviewed with registered nursing staff, the RAI Coordinator and Program Manager. As described to the Inspector, the home requests family members to complete a survey related to customary routines, including sleep. However, such information was not retrieved for resident #001 and therefore may not have been included as part of the resident’s plan of care.

In discussions with the resident’s sitter and nursing staff responsible for the care of resident #001, it was determined that the resident has atypical sleep patterns including poor sleep at night and varied need for sleep during the day. At the time of review, the plan of care did not include the needs and preferences of resident #001, as it relates to sleep patterns. [s. 6. (2)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 145. When licensee may discharge**

**Specifically failed to comply with the following:**

**s. 145. (1) A licensee of a long-term care home may discharge a resident if the licensee is informed by someone permitted to do so under subsection (2) that the resident’s requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident. O. Reg. 79/10, s. 145 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home may discharge a resident if the licensee is informed by someone permitted to do so, that the resident's requirements for care have changed and that, as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

In accordance with O.Regulation 79/10, s.145(1) and (2), in the case of a resident who is absent from the home, the licensee is informed that the resident's requirements have changed, by the resident's physician or a registered nurse in the extended class attending the resident.

Resident #002 has a medical history whereby the resident has been sent out to hospital numerous times related to socially inappropriate behaviour. In addition, there were two occasions, whereby the resident was involved with alleged sexual abuse of co-residents.

On one of these occassions, resident #002 was sent to hospital. The home maintained contact with the admitting hospital and made attempts to contact the placement coordinator and substitute decision maker for the resident to discuss next steps. As described by the Administrator of the home, six days after the hospital admission, the hospital was preparing to discharge the resident back to the home. The Administrator and management team involved believed there to be a risk to resident #002 and to other residents in the home and discharged the resident the next day.

Along with an interview with the Administrator, the Inspector reviewed the health care record. It was determined that information was not received from a physician or nurse in the extended class attending the resident, that the requirements of resident #002 had changed and that as a result, the home could no longer provide a secure environment to ensure safety. [s. 145. (1)]

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**Issued on this 13th day of October, 2016**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
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**Original report signed by the inspector.**