**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**

**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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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 21, Jul 4, 5, 2011 + June 22 | 2011_034117_0015 | Critical Incident |

**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**

LYNE DUCHESNE (117)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, the Resident Care Manager, to two Registered Nurses, to three Registered Practical Nurses, to nine (9) Personal Support Workers, to a resident, and to a mobility equipment specialist from Motion Specialty.**

**During the course of the inspection, the inspector(s) reviewed an identified resident's health care record, reviewed the home's Policy on Restraints-Physical/Mechanical # 08-10-02 (May 2010), reviewed the home's Resident Care Manual Policy # 05-07-03 on Personal Hygiene/Grooming - Subject: Bathing, reviewed the ARJO Alenti Tub Chair Lift Educational Training Highlights information pamphlet, examined the identified resident's wheelchair, wheelchair lap belt and bed side rails, examined a resident care unit's tub and shower room as well as examined five (5) commode shower chairs.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Minimizing of Restraining**

**Personal Support Services**

**Findings of Non-Compliance were found during this inspection.**

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**

| Definitions | Définitions |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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 O.Reg 79/10, s. 111. Requirements relating to the use of a PASD**

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

**s. 110. (2) Every licensee shall ensure that a PASD used under section 33 of the Act,**
**(a) is well maintained;**
**(b) is applied by staff in accordance with any manufacturer's instructions; and**
**(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111. (2).**

**Findings/Faits sayants :**

1. On June 21 at 14:45 MOHLTC inspector examined a resident care unit's tub and shower room. It was noted that the room has 5 commode shower chairs and 1 tub chair lift.

4 /5 commode shower chairs had the right side of a PASD (personal assistance safety device) belt in place. The left side of the PASD were missing.

Also noted, the frog clip closure, attached to the right side of one PASD, on one of the identified commode shower chairs, was broken.

The resident care unit's nursing staff stated that they had not noticed that 4/5 of the commode shower chairs on their unit were missing the left side of the PASDs nor that one frog clip closure was broken.

The resident care unit's nursing staff stated that they did not follow the home's maintenance policy to identify, report and remove the four commode shower chairs with missing left side PASDs from service as per the home's "lock out and tag out" maintenance process described to the MOHLTC inspector by the home's Director of Care and Resident Care Manager.

***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 PASDs (personal assistance safety devices) are well maintained , to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement**

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

**s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits sayants :**

1. An identified resident's plan of care identifies that the resident is at high risk for falls; and that the resident is in a wheelchair with a lap belt restraint for safety purposes.

The identified resident informed the MOHLTC inspector that he/she is seated on a commode shower chair when showered and that nursing staff apply a PASD (personal assistance safety device) to ensure his/her safety.

The identified resident stated to the MOHLTC inspector that he/she fell out of a commode shower chair when the PASD was undone by a Personal Support Worker after having been showered. The resident sustained a laceration.

A Registered Practical Nurse and a Personal Support Worker stated that a PASD had been applied and then removed during the identified resident's shower. They stated that the identified resident did fall from the commode shower chair when the PASD was removed and sustained a laceration.

Personal Support Workers who provide care to the identified resident stated to the MOHLTC inspector that they do apply a PASD when the resident is showered on a commode shower chair.

The resident's plan of care does not identify to the use of a PASD during the provision of a bath or shower.

The home's Director of Care and Assistant Director of Care confirmed to the MOHLTC inspector that the home does not identify the use of PASDs for resident baths or showers in residents plan of care.

**Issued on this 5th day of July, 2011**

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