Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 5, 2021	2020_627138_0018	003091-20, 005649-20, 007239-20, 008302-20, 012875-20, 013596-20, 015450-20, 015807-20, 016351-20	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

PAULA MACDONALD (138), EMILY PRIOR (732), MANON NIGHBOR (755)

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 7, 8, 9, 10, 11, 14, 15, 16, and 17, 2020.

The following intakes were inspected as part of this Critical Incident System inspection:
log #003091-20 - related to alleged abuse of a resident,
log #005649-20 - related to alleged abuse of a resident,
log #007239-20 - related to alleged abuse of a resident,
log #008302-20 - related to the fall of a resident,
log #012875-20 - related to the fall of a resident,
log #013596-29 - related to the fall of a resident,
log #015450-20 - related to alleged abuse of a resident,
log #015807-20 - related to alleged abuse of a resident and,
log #016351-20 - related to alleged abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Admissions Coordinator, the Administrator, both Assistant Director of Cares, both Clinical Care Coordinators, the Clinical Leader (The Ottawa Hospital Partnership Leadership Team), the Director of Care, the Manager (The Ottawa Hospital Partnership Leadership Team), the Office Manager, Personal Support Workers, Registered Nurses, Registered Practical Nurses, Resident Aides, the Resident Program Manager, residents, a Scheduler, the Social Worker, Support Services Aides, and the Support Services Manager.

The inspectors also observed residents and residential areas, observed infection, prevention and control (IPAC) measures, reviewed residents health care records, reviewed policies around abuse and notification in change of status.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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	Légende 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy in place to promote zero tolerance of abuse of residents was complied with for a resident.

A resident reported a situation of alleged abuse to a staff member. The home's abuse policy outlines measures to be taken as part of the zero tolerance of resident abuse which include immediate response to any alleged incident or abuse, timely internal reporting, and prompt investigation of reported incidents. No immediate actions were taken in the alleged abuse incident and instead actions were taken the following day, more that 24 hours later, when the resident reported the same incident to a different staff member.

Sources: Critical Incident Report, interviews with staff, progress notes, and Zero Tolerance of Resident Abuse and Neglect Program updated June 2019.

Log #016351-20 [s. 20. (1)]

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 the written policy in place to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of two residents occurred, immediately report the suspicion and the information upon which it is based to the Director.

An incident of alleged resident to resident abuse occurred and the incident was reported to the Director. Nursing management acknowledged the incident was reported late and indicated that staff did not follow the proper chain of reporting.

Sources: Critical Incident Report, interview with staff, progress notes for a resident, and incident report for a resident.

Log #003091-20 [s. 24. (1)]

2. An incident of alleged abuse occurred to a resident. The resident reported the incident of alleged abuse to a staff member who then reported concerns to another staff member. Nursing management confirmed that reporting of the incident to the Director did not occur immediately and instead occurred 4 days after staff became aware of the incident.

Sources: Critical Incident Report, interview with staff, and progress notes.

Log #016351-20 [s. 24. (1)]

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 any person who has reasonable grounds to suspect that abuse of a resident has occurred shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A resident was found with another resident on several occasions. Staff confirmed that the resident's substitute decision maker (SDM) was not contacted.

Nursing management indicated it is the home's practice to notify families in order for them to have the opportunity to participate fully in the development and implementation of the resident's plan of care.

By not involving the resident's SDM, there was an increased risk to the resident for future incidents.

Sources: progress notes for residents, interviews with staff, and Extendicare Notification of Family/Substitute Decision Maker Policy and Procedure.

Logs #015450-20 and #015807-20 [s. 6. (5)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that a post-fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls.

A resident suffered a fall with an injury. A post-fall assessment using a clinically appropriate tool was not completed for this specific fall.

Sources: post falls assessments, progress notes, and interviews with staff.

Log #013596-20 [s. 49. (2)]

Issued on this 7th day of January, 2021

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

Original report signed by the inspector.