Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: January 17, 2025
Inspection Number: 2025-1207-0001
Inspection Type: Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare West End Villa, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 9, 10, 13, 14, 15, 16, and 17, 2025

The following intake(s) were inspected:

- Intake: 00131686, CI: 2709-000014-24- An alleged incident of resident to resident physical abuse.
- Intake 00132063, CI: 2709-000015-24 - Improper/Incompetent care of a resident by staff unknown.
- Intake 00134216, Follow-up #: 1, issued in inspection 2024-1207-0006, - O. Reg. 246/22 - s. 23 (4) (b) related to air temperature, with a compliance due date (CDD) of January 6, 2025.
- Intake 00134394, CI: 2709-000016-24 - An incident that causes an injury to a resident
- Intake ., CI: 2709-000018-24 - An incident that causes an injury to a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1207-0006 related to O. Reg. 246/22, s. 23 (4) (b)

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that an action taken to respond to the needs of a

resident, in the form of assessing them using the Behavioural Supports Ontario - Dementia Observation System (BSO-DOS) tool, was documented.

On a day in the month of November 2024, a resident demonstrated physically responsive behaviors to another resident causing a fall. A BSO-DOS tool was initiated. The identified resident's observed behaviors were not consistently documented in 30 minute intervals for expected duration of a five day period, and there was no analysis of the data collected. Therefore, there was no assessment into what the data revealed, possible causes and contributing factors and next steps, using this tool.

Sources: Resident health care records, and interviews with staff.

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