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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 19, 2013	2013_029134_0010	000049-13, 000272-13	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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 17 and 18, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, several Registered Nurses (RN), several Registered Practical Nurses (RPN) several Personal Support Workers (PSW), several residents and family members.

During the course of the inspection, the inspector(s) reviewed three Residents' Health Records, a critical incident report and the Licensee's Internal Incident Investigation Report for Resident #3.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee failed to comply with O. Reg 79/10 s.36, in that it failed to use safe positioning techniques when assisting Resident #3 on an evening shift in December, 2012.

Resident #3 was a newly admitted resident. The admission plan of care was reviewed. There was an entry that specified that the resident required assistance with most aspects of care due to poor mobility, poor balance and cognitive loss. There is a second entry indicating the resident was able to self propel the wheelchair.

Staff member #S105, who was assigned to Resident #3 on the specified evening shift, was interviewed and indicated that the resident had been transferred into the wheelchair at the beginning of the shift. The resident then started to kick the wheelchair's footrests aggressively. The resident's behaviour was reported to the RPN who proceeded to administer the resident's 16:00 medication. Staff member #S106 then took the resident to the nursing station for observation and monitoring.

Staff member #S106, who was in charge of the unit on the specified date, was interviewed and reported to the inspector that Resident #3 was very agitated, was kicking at the wheelchair's footrests and was at risk of injuring self. The leg rests were removed from the resident's wheelchair and a straight armchair was placed in front of the resident to support feet and legs. Staff #S106 also indicated that the wheelchair was tilted at approximately a 45 degree angle. Staff member #S106 was unable to recall whether the wheelchair's headrest was in place to support the resident's head.

As per Resident #3's Substitute Decision Maker's report, the resident was found, on the specified date, in a poor body alignment in a tilted wheelchair, with no support for feet or head. The resident was on his/her back with legs, arms and head in the air, helplessly fighting to get self up to a comfortable position. The resident was allegedly upset and struggling.

Staff #S106 indicated that the resident had been kicking and pushing the armchair away and so it was possible that when the Substitute Decision Maker arrived, that the resident's legs were not well supported due to agitation.

Staff #S101, who was assigned to Resident #3 on the day shift of the specified date in December 2012, was interviewed. Staff #S101 indicated that Resident #3 did not require leg rests on the chair as the resident was able to self propel independently

and as such would not accept the wheelchair to be tilted back.

Staff #S100, #S102, #S103 and #S104, who worked the day shift of April 18, 2013, were interviewed individually. All reported that it would not be the usual intervention to tilt a resident's wheelchair backward when a resident was agitated.

The Seating and Mobility Consultant from Ontario Medical Supply was interviewed by the Inspector April 18, 2013. As per the Consultant's statement, the wheelchair should never have been tilted while the resident was sitting in it without the leg rests in place for support to the lower extremities. The Consultant added that Resident #3 was able to self propel independently and therefore did not require leg rests when in an upright position.

As such staff failed to use safe positioning techniques when assisting Resident #3 in the wheelchair while agitated. [S. 36.]

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 staff use safe positioning techniques when assisting a resident in a reclined wheelchair and more specifically to ensure that the resident's wheelchair is not tilted back when the leg rests have been removed, to be implemented voluntarily.

Issued on this 23rd day of April, 2013

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

Colette Asselin, LTCH Inspector # 134