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 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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Oct 10, 11, 12, 15, 2012	2012_198117_0001	Critical Incident

Licensee/Titulaire de permis

~~NEW ORCHARD LODGE LIMITED~~ Extendicare (Canada) Inc. [initials] 15-10-12.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE, OTTAWA, ON, K2B-5E6

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 Administrator, Director of Care, Assistant Director of Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, several Activity Aids, a housekeeper, of a Ministry of Health - Health Data Branch Analyst and to several residents

During the course of the inspection, the inspector(s) reviewed several identified residents health care records, observed care and services given to several residents,reviewed the home's Wanderguard and door security systems, reviewed the home's Outbreak Management Protocols for January 23 2012 enteric outbreak and September 17 2012 respiratory outbreak, reviewed the home's 2011 and 2012 staff training program on Abuse and Zero Tolerance, reviewed the home's Resident Abuse and Neglect policy # OPER-02-02-04, reviewed four Critical Incident Reports.

It is noted that during this inspection, four Critical Incident inspections were conducted : Log # O-000246-12, # O -000376-12, # O-000528-12 and #O-001004-12.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Safe and Secure Home

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 23 (2) as the licensee did not report to the Director the results of two investigations related to two incidents of alleged resident abuse.

1- On an identified day in February 2012, resident #2 had an injury that required further assessment. The resident was transferred to hospital and was diagnosed with a fracture. The licensee completed and submitted a Critical Incident report to the Director related to the resident's injury and transfer to hospital.

The home's Director of Care and Assistant Director of Care initiated an investigation into the cause of the resident's injury. Ottawa Police Services Elder Abuse unit, who had been contacted by the hospital regarding the resident's injuries, also conducted an investigation into the cause of the resident's injury. Both investigations concluded that the cause of the resident's injury is unknown. It was noted that resident #2 has underlying medical conditions that may have contributed to the injury. The police noted that there was criminal intent.

The home did not report the findings of their investigation to the Director. (log # O-000528-12)

2- In April 2012, a staff member #S100 reported an alleged incident of staff to resident verbal abuse to the home's Administrator. The Administrator immediately initiated an investigation into the alleged incident of verbal abuse.

The Administrator reported the alleged incident of verbal abuse to the Director via a Critical Incident. The internal investigation was completed a few days later. No evidence of abuse was found. The Administrator did not communicate the findings of the completed investigation to the Director. (log # O-001004-12)

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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 24 (1) (1) as it relates to an incident of alleged verbal abuse towards a resident was not immediately reported to the Director.

On an identified day in April 2012, a staff member #s100 reported an alleged incident of staff to resident verbal abuse to the home's Administrator. The Administrator immediately initiated an investigation into the alleged incident of verbal abuse.

3days - LD 16oct'12.

The Administrator reported the alleged incident of verbal abuse to the Director via a Critical Incident report ~~six~~ days after being made aware of the alleged incident. The Administrator did not immediately report the alleged incident of verbal abuse to the Director. (log # O-001004-12)

Issued on this 15th day of October, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
LHawkins for L. Duchesne Oct, 15, 2012