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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 3, 2015	2015_290551_0014	O-001428-14, O-002102-15	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

MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 26-29, 2015.

During the course of the inspection, the inspector(s) observed residential and non-residential areas, reviewed health care records and observed resident and staff interactions.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, the Nutritional Care Manager, the Manager of Maintenance Services, an Assistant Director of Care, the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the nutritional plan of care was provided to Resident #1 as specified in the plan.

Resident #01 has an allergy to a specific food. The resident's nutritional plan of care states that he/she has a customized diet which, according to the Nutritional Care Manager, consists of individualized meal and nourishment menus.

On a specified day during the evening nourishment pass, Resident #01 was given a sandwich that contained a filling to which he/she has a documented allergy to.

PSW, Staff Member #102 stated that she was circulating the evening nourishment cart on the day of the incident and gave Resident #01 a sandwich containing a specific filling after the resident saw bread on the cart and insisted on eating it. Staff Member #102 stated that she was not aware at that time that Resident #01 was allergic to the specific food in the sandwich.

RN, Staff Member #101 stated that he was working the evening of the incident and was called by the unit nurse to report that Resident #01 had consumed a specific food to which the resident was allergic to. Staff Member #101 stated that when he went to assess the resident, he noted that Resident #01 was wearing an allergy bracelet, and that there was a sign in the resident's room stating that the resident was not to receive the specific food that he had consumed at snack time.

Staff Member #102 stated that following the incident, she looked and saw that there was a labelled snack for Resident #01. [s. 6. (7)]

Issued on this 3rd day of July, 2015

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

Original report signed by the inspector.