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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 13, 2016	2016_200148_0033	010490-16, 025747-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
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

AMANDA NIXON (148)

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): September 28, 29 and 30, 2016

This inspection included two critical incidents both related to alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, RAI Coordinator, Admissions Supervisor, Staffing Coordinator, Program Manager, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), residents and family members.

The Inspector also reviewed resident health care records, documents associated with the home's investigations into the identified alleged abuse incidents and staffing schedules.

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

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care are documented.

A critical incident was reported to the Director/MOHLTC describing an incident that occurred on a specified date. In the early morning hours, resident #002 was found in the bed of resident #001, who was not wearing any clothes at the time. The initial report noted that resident #002 was placed on behavior monitoring; the amended report to the Director, noted hourly behavior monitoring.

Inspector #148 reviewed the health care record, specific to the resident's responsive behaviours. The resident's plan of care, as it relates to behavioural symptoms, indicates that the resident is to be monitored every two hours for safety.

The Inspector spoke with PSW #100 who was assigned to the care of resident #002 on September 29, 2016, and regular day shift PSW #101. Both staff persons noted behaviours of physical aggression and resistance to care. During questioning of behavior monitoring, both staff indicated that there was no monitoring at this time.

A review of flow sheets and other documentation maintained by both PSW and registered nursing staff indicates that mood and behavior are noted each shift (day, evening and night). There was no documentation to support two hour monitoring of the resident's behaviours as indicated by the plan of care. [s. 6. (9) 1.]

Issued on this 13th day of October, 2016

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

Original report signed by the inspector.