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
Jul 17, 2017	2017_582548_0011	010324-17	Complaint

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

RUZICA SUBOTIC-HOWELL (548)

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): June 5, 6,7,8 and July 10 and 11, 2017

During the course of the inspection the inspector observed staff to resident care and interaction, observed the resident on several different occasions, reviewed resident's health care records and home policies.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Physician, Office manager, Registered nurses, Registered practical nurses, Personal support workers, Dietary aide and Substitute decision-makers.

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

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 O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The Licensee has failed to ensure the resident's substitute decision-maker is notified

when new personal belongings are required.

A complaint was received by the resident's substitute decision-maker (SDM) for the review of the content of personal clothing available for resident #001.

On a specified day in June 2017 Inspector #548 observed the resident's closet items, counted and identified the articles.

The Inspector #548 was unable to open two dresser drawers as both drawers were wedged sideways filled with clothing. The inspector was unable to verify what the clothing items were in the drawers.

On a specified day and time in June 2017 Inspector #548 observed resident #001 to be dressed in dark gray sweatpants, light gray short sleeved shirt, dark socks, clean black thick tread shoes.

A day later Inspector #548 observed resident #001 to be seated in a sitting area dressed in different light gray short sleeved shirt, dark sweat pants, socks and same dark black shoes.

Two days later Inspector #548 observed resident to be seated in a chair outside of the elevator dressed in light gray short sleeved shirt, dark gray sweat pants, socks and dark black shoes.

On a specified day in July 2017 Inspector #548 observed the resident's #001 closet to hold three pairs of dark coloured pants, two which are dress pants and several styles of shirts. There was one white sock in one of the drawers.

That same day Inspector #548 observed that no socks were available for resident #001 while the resident was being dressed by personal support workers (PSW) #100 and #101. It was observed that the two PSWs put dark black shoes on the resident's feet with no socks. During an interview with Inspector #548 PSW #100 indicated that there are times when they do not have sufficient clothing supplied for the resident. She indicated that they inform the registered nursing staff when this happens.

On July 11, 2017 during an interview with the office manager she indicated that the resident's #001 family is responsible to purchase personal belongings and provide the expense receipt to PGT for reimbursement.

On July 17, 2017 during an interview with Inspector #548 RN #103 indicated that when she is informed that a resident requires new personal belongings she informs the resident's first contact person. She indicated that she always contacts the primary contact as identified in the resident's health care record. She further indicated that as she was not aware that the resident required new clothing therefore the SDM's had not been informed. [s. 38. (b)]

Issued on this 17th day of July, 2017

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

Original report signed by the inspector.