Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2019	2019_617148_0025	012771-19, 012977-19, 013873-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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 Complaint inspection.

This inspection was conducted on the following date(s): August 26-30, 2019

This inspection included the following complaints: Log 012977-19, related to the fall of an identified resident that resulted in injury and transfer to hospital and Log 012771-19, related to CIR #2709-000021-19, which was included in the complaint inspection as it related to the same fall of the same resident. Additionally, this inspection also included Log 013873-19 related to the care and services provided to an identified resident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Support Services Manager, the two Clinical Care Coordinators, Ward Clerk, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aide and an identified resident.

In addition, the Inspector reviewed the health care records of the identified residents and policies and procedures related to resident room cleaning. The resident care environment was observed along with aspects of resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe environment for resident #001.

On a specified date, resident #001 had an unwitnessed fall in the resident's bedroom. The resident was found by Housekeeping Aide #102 who immediately called for assistance, whereby RPN #100 responded. The resident was assessed and sent to hospital where an injury was confirmed.

The post fall assessment completed by RPN #100 indicated a wet floor as a contributing factor to the fall as the housekeeping aide had just completed a wash of the floor. The post fall assessment further indicated that to prevent the fall a sign would be needed to indicate that the floor is wet.

Inspector #148, interviewed RPN #100 who indicated that when the resident was discovered, the floor was damp. In an interview with Housekeeping Aide #102, it was reported that the floor was wet and dry mopped while the resident was in the room, resting in bed. Housekeeping Aide #102 provided instruction to resident #001 to remain in bed, until the floor was dry. Housekeeping Aide #102 left the room placing a wet floor sign at the doorway. Upon coming to the room to retrieve the wet floor sign, Housekeeping Aide #102 discovered the resident on the floor.

In this way, the resident's bedroom environment was not safe, contributing to a fall and injury.

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 the home is a safe environment for the resident, to be implemented voluntarily.

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.