Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: April 5, 2023	
Inspection Number: 2023-1207-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare West End Villa, Ottawa	
Lead Inspector Cheryl Leach (719340)	**Inspector Digital Signature** Cheryl Leach Digitally signed by Cheryl Leach Date: 2023.04.05 14:03:58 -04'00'
Additional Inspector(s) Sarah Stephens (740823) Shevon Thompson (000731)-Present as an observer	

INSPECTION SUMMARY

The inspection occurred on the following date(s): March 2, 3, 6, 7, 8, 9, 10, 13 and 14, 2023.

The following intake(s) were inspected:

- Intake: #00002106-[CI 2709-000007-22] Fall of resident resulting in transfer to hospital and significant change in condition.
- Intake: #00003496-[IL-03284-OT] Family complaint regarding delayed notification of death of a resident and continence care.
- Intake: #00005134-[IL-04548-AH/CI: 2709-000013-22] Fall of resident resulting in transfer to hospital and significant change in condition.
- Intake: #00005365-[IL-03959-AH/CI: 2709-000012-22] Unexpected death of resident.
- Intake: #00006706-[IL-02610-OT]/IL-04007-OT] Family complaint regarding physician visits for resident.
- Intake: #00011066-[IL-06318-OT] Anonymous complaint regarding staff and resident care.
- Intake: #00012358-[IL-06801-AH/CI 2709-000019-22] Fall of resident resulting in transfer to hospital and significant change in condition.
- Intake: #00019636-[IL-09785-AH /CI 2709-000003-23] Fall of resident resulting in transfer to hospital and significant change in condition.
- Intake: #00020445-[IL-10082-OT] Coroner complaint regarding death of a resident.

- Intake: #00020550-[IL-10131-AH /CI 2709-000004-23] Fall of resident resulting in a transfer to hospital and a significant change in condition.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care for Personal Assistance Service Device (PASD)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the plan of care for a Personal Assistance Service Device (PASD) was provided to a resident as specified in the plan.

Rationale and Summary

The resident's care plan indicated that a PASD was to be used for safety while in the wheelchair. The resident had an unwitnessed fall sustaining an injury resulting in a transfer to hospital and a significant change in condition. Interviews with staff members confirmed that the resident was not wearing their PASD device in the wheelchair at the time of the unwitnessed fall. Interview with staff member confirmed that it would not be possible for the resident to fall from the wheelchair if their PASD device was in place. The Post Fall Huddle Tool indicated that a PASD was not in place at the time of the unwitnessed fall. The resident was placed at risk by not having the PASD device in use for safety in the wheelchair at the time of the unwitnessed fall as per the plan of care.

Sources: Staff interviews and resident ’s progress notes, care plan and assessments.

[719340]