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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2013	2013_230134_0022	O-000897-13, O-001012-13	Critical Incident System

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

COLETTE ASSELIN (134)

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): November 26, 27 and 29, 2013

Two critical inspections log # O-000897-13 and log # O-001012-13 were conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

During the course of the inspection, the inspector(s) toured the unit, reviewed the Resident Abuse and Neglect Policy # OPER-02-02-04 and the internal critical incident investigation reports.

The following Inspection Protocols were used during this inspection:
Admission Process

Dignity, Choice and Privacy

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with the LTCHA, 2007 S.O. 2007, c. 8 s. 3 (1) 1, in that one staff member did not treat Resident #3 with respect and in a way that fully recognized the resident's individuality and respected the resident's dignity as per direction provided on plan of care.

Resident #3 has a diagnosis of dementia. The plan of care was reviewed and there is an entry indicating the resident's walks and wanders on the unit. Under section "mood state" there are clear directions that specify; to use gentle, persuasive approach, distract and re-approach. Under section communication, there is an entry that indicates to allow the resident time to speak, use a gentle calm approach to prevent response behaviours.

Staff member #S100 was interviewed and indicated that when Resident #3 was admitted to the unit staff observed that he/she had a tendency of gravitating toward the medication cart and serving self food items from the top of the cart. According to Staff member #S100 the practice on the unit is to take all food items off the medication cart and to place them inside the cart to prevent this resident and others from serving themselves.

On a specified date in September 2013, there was a witnessed allegation of physical and verbal abuse between a nurse and Resident #3, as reported in the Critical Incident Report.

The witness reported the incident to the Director of Care (DOC) on a specified date in September 2013. The report indicated the staff member was witnessed to have raised his/her voice and seemed angry when Resident #3, took food items from the top of the medication cart. This staff member was witnessed by another staff to have been physically and verbally abusive toward Resident #3. According to the witness the resident appeared upset by the incident.

As such, Resident #3 was not treated with respect and courtesy as per direction provided in the plan of care. [s. 3. (1) 1.]

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 all residents with responsive behaviours are treated with respect and dignity in a way that fully recognizes their individuality by implementing care approaches provided in the plan of care, to be implemented voluntarily.

WN #2: 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 failed to comply with the LTCHA, 2007 S.O. c.8 section 6 (7), in that care set out in plan of care as it relates to risk of falls was not provided as specified in the plan.

On a specified date in October 2013, Resident #4 was found on the floor at the foot of the bed. He/she was transferred to hospital and was diagnosed with a head injury. This fall caused a significant change in the resident's condition. The resident is now wheelchair bound, uses a seat belt and requires to be transferred by maxi lift. The risk of falls is evaluated as high and now requires to have the bed in its lowest position, with mats placed on both sides of the bed and to have the tab alarm fastened to the resident's clothing when in bed.

The plan of care was reviewed and there is an entry that specifies "Tab Alarm" installed over head of bed, attach to resident when in bed.

On November 26, 2013, the inspector visited Resident #4 at approximately 14:00. The resident was in bed sleeping, with call bell accessible but the tab alarm was not attached to the resident. Both mats were on the floor and the bed was in its lowest position at the time.

PSW #S102 was interviewed and reported that the bed alarm is to be attached at all times when resident is in bed.

As such, the care set out in the plan was not provided as specified in the plan. [s. 6. (7)]

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 care set out in Resident #4's plan of care, related to prevention of fall and injury, is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Licensee has failed to comply with the LTCHA, 2007 S.O. c.8 section 24 (1), (2), in that an allegation of staff to resident abuse was not reported immediately to the Director.

As per Critical Incident Report submitted on a specified date in September 2013, there was an allegation of staff to resident abuse where one staff member allegedly raised his/her voice and tone toward Resident #3, who was taking food items off the medication cart. This staff member was also observed to been physically abusive toward the resident, which made the resident loose balance.

The DOC was interviewed by the inspector and indicated the home was late in reporting to the Director as per legislative requirement. The allegation of abuse was not reported until seven (7) days after the allegation of staff to resident abuse incident occurred.

As such, the Director was not notified immediately of an allegation of staff to resident abuse. [s. 24. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The Licensee failed to comply with the O. Reg 79/10 s. 107 (3.1) (a), in that the Director was not notified within three days when Resident #4 fell and sustained an injury that required transfer to hospital and where there was a significant change in condition.

As per Critical Incident Report, Resident #4 was found on the floor on a specified date in October 2013. The resident required a transfer to hospital and the injury resulted in a significant change in condition. This resident was ambulatory and continent and as a result of the fall he/she is now wheelchair bound, uses a seat belt and requires to be transferred by maxi lift.

The home submitted the critical incident report to the MOHLTC eight days after the incident occurred.

As such, the Director was not notified as per legislative requirement. . [s. 107. (3.1) (a)]

Issued on this 11th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134