Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Mar 13, 2020	2020_818502_0008	003623-20, 004025-20	Critical Incident System

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 Starwood
114 Starwood Road NEPEAN ON K2G 3N5

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

JULIENNE NGONLOGA (502)

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): March 10, 11 and 12, 2020.

During the course of the inspection, the following Critical Incident (CI) were inspected:
- CI #2485-000003-20 (log #003623-20) and CI #2485-000004-20 (log #004025-20) related to an allegation of abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Support Service Manager, residents and family member of the resident.

During the course of this inspection, the inspector observed staff and resident interactions, resident to resident interaction, and reviewed the residents' health care records, the licensee investigation notes and relevant policies and procedures.

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)**
- **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 :

1. The licensee has failed to ensure that the home was a safe and secure environment for resident #002.

The Ministry of Long-Term Care received Critical Incident System report (CIS) related to an allegation of resident to resident abuse. The CIS indicated that resident #001 pushed resident #002's wheelchair out of the way while ambulating in the unit resulting in an injury.

Review of the of the progress notes indicated that on an identified date and time, RPN #104 heard resident #002 screaming while being pushed by resident #001. On observation, RPN #104 noted that resident #002's leg was caught under the a specified equipment stored in the hallway resulting in a specified injury and was transferred to hospital for treatment.

On two occasions, the inspector observed that equipment were stored on the left side of the hallway and the residents ambulated on the right side of a specified care area. Further observation of the specified care area indicated that two piece of equipment had harp edge. This was confirmed by the Support Services Manager (SSM).

In an interview with RPN #104, they confirmed that the incident described above. The RPN indicated that the sharp edge on the specified piece of equipment caused the injury to resident #002.

In an interview with SSM, they indicated that they were not aware of the sharp edge on specified piece of equipment. They indicated that they were not safe for residents and they will take steps to protect the sharp edge. The temporary intervention to reduce the risk of injury to residents was not in place at the end of this inspection, therefore the specified care area was not a safe and secure environment for resident #002 and other residents. [s. 5.]

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 was a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 16th day of March, 2020

[redacted]

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

Original report signed by the inspector.