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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Feb 18, 2021	2021_809733_0001	006142-20, 009424-20, 011993-20, 013464-20, 025350-20	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

MARK MCGILL (733), LYNE DUCHESNE (117)

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): February 2, 3, 4, 5, 8, 9, 10, 11, 2021

log 006142-20 (CIS: 2485-000006-20), log 009424-20 (CIS: 2485-000008-20), log 011993-20 (CIS: 2485-000011-20) are related to falls.
log 025350-20 (CIS: 2485-000018-20) is related to alleged staff to resident physical abuse.
log 013464-20 (CIS: 2485-000013-20) is related to an eloped resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care (ADOC), the Director of Care (DOC), personal support workers (PSW), housekeeping, a ward clerk and registered nurses (RN). The inspector(s) also observed the provision of care and services to residents, residents and their rooms, common areas, staff to resident interactions, and the use of infection prevention and control measures and personal protective equipment by staff. The inspector(s) also reviewed the residents' health care records. IPAC observational checklist A2 was also completed by the inspectors.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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 :

The licensee has failed to ensure that the care was provided to resident #003 as specified in their plan of care.

A resident's plan of care identifies that the resident can have responsive behaviours during the provision of care. Staff are to explain care to be provided prior to initiating care. If the resident is unwilling to receive care, staff are to leave and re-approach later and to inform registered staff.

In December 2020, a PSW provided care to the resident. The resident presented with behaviours and hit out at the PSW. The PSW continued to provide care and the resident sustained an injury.

The PSW said that they reported the resident behaviours and injury to registered staff. They said that they were aware of the resident's care plan interventions but continued with provision of care even when the resident had behaviours.

An ADOC who was present at the time of the incident as well as the home's Administrator and DOC, who conducted an internal investigation into the incident, said that the PSW was aware of the resident's care needs and did not follow the resident's plan of care for when the resident presents with behaviours. As such, due to the staff not following the plan of care, the resident sustained injuries.

Sources: Staff interviews PSW, ADOC, DOC, Administrator, Resident Plan of Care and health care records. [s. 6. (7)] (117)

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 care is provided to a resident as specified in their plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home were kept locked and are equipped with an audible door alarm that is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door.

A resident eloped from the long term care home through two service doors located in the hallway between the main doors and a resident unit. The resident was found shortly afterwards by police.

The door had an audible alarm that sounded only at the location of the door and was not connected to an enunciator system elsewhere in the home. At the time of the elopement, the alarm had been bypassed through the use of a key by an unidentified staff member. The staff failed to lock and reset the door alarm, putting the residents at risk and specifically allowing a resident to exit the home.

Sources: Critical Incident Report; Interviews with Administrator and ADOC, record review of a resident’s chart. [s. 9. (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 that all doors leading to the outside of the home are kept locked and are equipped with an audible door alarm that is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door, to be implemented voluntarily.

Issued on this 23rd day of February, 2021

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

Original report signed by the inspector.