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
Jul 25, 2014	2014_284545_0018	O-000469-14, O-000472-14	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

ANGELE ALBERT-RITCHIE (545)

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): July 3 and 4, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Clinical Coordinator, one Registered Nurse (RN), two Registered Practical Nurses (RPN), and several Personal Care Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the health records for Resident #001 and Resident #002, reviewed the home's Falls Prevention and Management Program Policy Reference # RESI-10-02-01, version April 2013, observed interaction between staff and residents and observed care and services provision to Residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s .107 (1) 2 in that the home did not ensure that the Director was immediately informed, in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident or suicide.

A Critical Incident Report was submitted by the home for the unexpected death of Resident #001.

Upon review of health record it was noted that on a specific date in May 2014 early morning Resident #001 was found on the floor of his/her bathroom with two small skin tears on the right arm and a large hematoma on the right side of the forehead. At a later time on the same date, Resident #001 was found by staff in his/her chair with no pulse; coroner was contacted and unexpected death was pronounced.

In an interview with the Director of Care on July 4, 2014 she indicated that she was on-call on the date of the critical incident and came to the home as soon as she was notified of Resident #001's unexpected death. The DOC indicated that she informed the Director of Resident #001's unexpected death 6 days post critical incident.

As such the home did not ensure that the Director was immediately informed, in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident or suicide. [s. 107. (1) 2.]

Issued on this 25th day of July, 2014

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