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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2017	2017_593573_0016	005183-17, 007831-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) 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

ANANDRAJ NATARAJAN (573)

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 31, 2017 and August 01, 02, 03 and 04, 2017.

Critical Incident Log #005183-17 related to staff to resident alleged emotional abuse/ neglect and Log #007831-17 related a resident to resident alleged sexual abuse was inspected during this inspection. Concurrently Complaint Inspection Log #009114-17 was inspected during this inspection. Non-compliance related to Complaint Inspection #2017_593573_0017 / 009114-17 will be addressed in this report.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN) and Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

Inspector reviewed critical incident reports, residents health care record including care plans, assessments, progress notes, Medication/Treatment administration records (MAR/TAR) and staff training records. In addition Inspector observed the provision of care and services to the resident and observed staff to resident interactions.

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	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 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 ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg 79/10 s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #002 was admitted in the home with responsive behaviours and was receiving medications to manage behaviours. It was confirmed through review of health care records and interviews with registered nursing staff and the home's DOC, that resident #004 has cognitive deficits and does not have the capacity to give consent to touching of a sexual nature.

On August 01, 2017, during a review of resident #002's health care record, Inspector #573 noted progress note on a identified date and time, indicated that RN #100 heard resident #004 calling out, further the RN found resident #002 in resident #004's bedroom with his/her pants undone. It was observed by the RN that resident #004's underwear was undone and resident #002 hands were on resident #004's legs. Resident #002 was immediately removed from the situation.

On August 02, 2017, Inspector #573 spoke with the home's DOC who indicated that the resident to resident alleged sexual abuse incident on a identified date was not reported to the Director. The DOC indicated to the inspector that she was not made aware of the incident, by the RN #100. Further she indicated that RN #100 should have contacted the DOC or the Administrator immediately upon becoming aware of the incident as they were the manager on call, who would report to the Ministry of Health and Long Term Care. (Log# 007831-17) [s. 24. (1)]

2. In accordance with O.Reg 79/10 s.2 (1), physical abuse means the use of physical force by a resident that causes physical injury to another resident.

On a specified date Ministry of Health and Long Term Care Info line was contacted by a complainant to report an incident where resident #005 was pushed by a resident, resulting in resident #005's fall and injury. During the inspection resident #006 was identified as the person who pushed resident #005.

Resident #006 was admitted in the home with responsive behaviours. Resident #006 health care record indicated that for responsive behaviours,the resident was assessed by the Home's Physician and by the Psycho Geriatric Team (Nurse and Physician). Medications and treatments were reassessed on an ongoing basis and readjusted to minimize the responsive behaviours.

During a review of resident #006's progress notes, three incidents of alleged resident to resident physical abuse were identified within three specific months in 2017.

- On a specified date, a physical altercation incident whereby resident #006 pushed resident #007, resulted in resident #007's fall and Injury.

- On a specified date, a resident #006 to resident #008 physical altercation incident resulted in Injury.

- On a specified date, a resident to resident physical altercation incident whereby resident #006 pushed resident #005, resulted in resident #005's fall and Injury.

On August 03, 2017, Inspector #573 spoke with the home's ADOC who indicated that the above identified three incidents of alleged physical abuse that caused physical injury were not reported to the Director. (Log #009114-17) [s. 24. (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 a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 1st day of September, 2017

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

Original report signed by the inspector.