Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Mar 28, 2018	2018_593573_0004	027653-17, 002551-18	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): February 27 and 28, 2018 and March 05 - 09, 2017.

Critical Incident Log #027653 -17 and Log #002551-18 related to staff to resident alleged physical abuse was inspected during this inspection.

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), Registered Practical Nurses (RPN), Personal Support Workers (PSW), resident's Substitute Decision Maker (SDM) and residents.

Inspector reviewed critical incident reports, documents related to the licensee's investigation into the identified alleged incidents of abuse, 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:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident’s substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident’s Substitute Decision Maker (SDM) was immediately notified of the results of the investigation of the alleged physical abuse of resident #001.

A Critical Incident Report was submitted on an identified date in 2018, to the Director for an alleged staff to resident physical abuse.

The home’s Assistant Director of Care (ADOC) #108 indicated during an interview on February 28, 2018, with Inspector #573 that an investigation related to the allegation of physical abuse of resident #001 was initiated immediately. The ADOC #108 also indicated that the investigation results failed to verify that abuse of resident #001 had occurred.

Inspector #573 reviewed the licensee’s investigation documentation related to the allegation of physical abuse of resident #047. The Inspector was unable to locate any documentation indicating that resident #001’s SDM was notified of the results of the alleged abuse investigation.

Inspector #573 spoke with ADOC #108, who indicated to Inspector #573 that the investigation was completed, and that the licensee failed to notify resident #001’s SDM of the results of the alleged abuse investigation immediately upon completion. (Log #002551 -18) [s. 97. (2)]

Issued on this 29th day of March, 2018

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

Original report signed by the inspector.