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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 3, 2019	2018_717531_0027	019632-17, 021723-17, 004612-18, 004954-18, 005789-18, 005915-18, 009340-18, 012602-18, 013950-18, 018507-18, 020215-18, 024678-18, 025103-18, 026927-18	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

SUSAN DONNAN (531)

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): December 5, 10, 11, 12, 13, 14, 17, 18, 19 and 20, 2018.

The following logs were completed concurrently during this inspection:
log #019632-17, CIS #2485-000013-17, related to alleged resident to resident physical abuse
log #004612-18, CIS #2485-000009-18, related to alleged resident to resident physical abuse
log #024678-18, CIS #2485-000027-18, related to alleged resident to resident physical abuse
log #018507-18, CIS #2485-000024-18, related to alleged resident to resident physical abuse
log #025103-18, CIS #2485-000028-18, related to alleged resident to resident physical abuse
log #005789-18, CIS #2485-000010-18, related to fall prevention
log #009340-18, CIS #2485-000016-17, related to fall prevention
log #020215-18, CIS #2485-000025-18, related to fall prevention
log #013950-18, CIS #2485-000023-18, related to fall prevention
log #021723-17, CIS #2485-000014-18, related to fall prevention
log #026927-18, CIS #2485-000031-18, related to fall prevention
log #004954-18, CIS #2485-000006-18, related to fall prevention
log #012602-18, CIS #2485-000022-18, related to fall prevention
log #005915-18, CIS #2485-000011-18, related to fall prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the two Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physician, a Housekeeping staff (HKP), Behavioual Support staff (BSO), Residents' Decision Maker (SDM) and residents.
During the course of the inspection, the inspector conducted a walking tour of the home, reviewed resident health care records, observed resident care and services, reviewed the abuse policy and procedures and the fall prevention policy and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was informed no later than one business day of an incident that caused an injury to resident #002 for which the resident was taken to hospital and that resulted in a significant change to the resident.

On a specified date CIS report #2485-000014-17 was submitted to the Director which indicated that on the particular date, resident #002 had fallen, sustained an injury that required a transfer to the hospital .

During an interview with the Administrator and review of the critical incident report, they indicated that the incident was not reported to the Director until a specified date, eight days after the incident.

The licensee failed to ensure that the Director was notified no later than one business day of an incident that caused an injury to resident #002. [s. 107. (3)]

Issued on this 3rd day of January, 2019

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

Original report signed by the inspector.