Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: March 2, 2023	
Inspection Number: 2023-1078-0002	
Inspection Type: Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Starwood, Nepean	
Lead Inspector Cheryl Leach (719340)	**Inspector Digital Signature** Cheryl Leach Digitally signed by Cheryl Leach Date: 2023.03.02 12:12:43 -05'00'
Additional Inspector(s) Kayla Debois (740792) Marko Punzalan (742406)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 18, 19, 20, 23, 24, 25, 26 and 27, 2023.

The following intake(s) were inspected:

- Intake: #00002747-[CI 2485-000029-22] Missing resident.
- Intake: #00006161-[IL-04616- AH/CI 2485-000030-22] Fall with injury resulting in significant change in condition.
- Intake: #00011221-[CI 2485-000032-22] Fall with injury resulting in significant change in condition.
- Intake: #00012128-[CI 2485-000034-22] Resident to resident sexual abuse.
- Intake: #00013587-[CI 2485-000036-22] Resident to resident physical abuse.
- Intake: #00014625-[CI 2485-000037-22] Fall with injury resulting in significant change in condition.
- Intake: #00018099-[CI 2485-000002-23] Fall with injury resulting in significant change in condition.
- Intake: #00018153-[IL-09173-AH/CI 2485-000003-23] Alleged resident to resident sexual abuse.

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care-Falls Management

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that a fall intervention for a resident who is a high risk for falls was in the plan of care.

Rationale and Summary:

Staff member failed to ensure a fall intervention was in place for a resident. The resident fell and sustained an injury. The fall risk assessment indicated that the resident was a high risk for falls and the Falls Management Policy stated to implement S.A.F.E. Universal Falls Precautions for all residents. The plan of care for the resident at the time of the fall did not have the fall intervention identified. Failure to ensure that fall interventions are identified in the plan of care places the resident at increased risk for injury.

Sources: Plan of care, fall risk assessment and progress notes, staff interviews and Falls Management Policy.

[719340]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that an intervention for responsive behaviours for a resident was followed as per the directed requirements in the resident's plan of care.

Rationale and Summary:

The Plan of Care for the resident included an intervention for responsive behaviours which was not followed resulting in an incident with another resident.

By not ensuring the intervention for responsive behaviours was followed, the resident was able to make physical contact with another resident that was non-consensual.

Sources: Plan of care, progress notes and staff interviews.

[742406]

WRITTEN NOTIFICATION: External Door Access System

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 1. ii.

The licensee has failed to ensure that all doors leading to the outside of the home are equipped with a door access system that is kept on at all times.

Rationale and Summary:

Resident eloped from the home through an external door.

Staff confirmed that the external door was unlocked and the alarm had been bypassed for a delivery and the staff member did not lock and reset the door alarm upon completion. The door-locking mechanism was deactivated and not reactivated, and the staff member did not notice that the door was unlocked until the resident was brought back to the home.

By not ensuring that the door access system was kept on at all times for doors leading outside of the home, an unsupervised resident wandered outside of the home, posing a risk of harm to the resident.

Sources: Staff interview and investigation notes.

[740792]

WRITTEN NOTIFICATION: Responsive Behaviour Interventions

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that an immediate intervention was applied for a resident's responsive

behaviour.

Rationale and Summary:

Resident eloped from the home through an external door. The resident had a history of exit seeking responsive behaviours. The home is equipped with an exit alarm system for residents who demonstrate exit seeking responsive behaviours. Staff members stated that the resident did not have the exit alarm system in place when they eloped from the home and it was not initiated until several days after the resident had eloped.

By not ensuring interventions were applied for wandering behaviours, an unsupervised resident eloped from the home, posing a risk of harm to the resident.

Sources: Staff interviews, investigation notes, progress notes and care plan.

[740792]