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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Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 19, 2023
Inspection Number: 2023-1078-0003
Inspection Type: Complaint Critical Incident System
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Starwood, Nepean

Lead Inspector	**Inspector Digital Signature**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.06.28 12:03:37 -04'00'

Additional Inspector(s)
Dee Colborne (000721)
Jessica Nguyen (000729)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12, 13, 14, 2023

The following intake(s) were inspected:

- Intake: #00086314 - IL-12422-OT Complaint from coroner, concerns regarding resident care.
- Intake: #00087350 - 2485-000009-23 Unwitnessed fall resulting in injury to resident causing significant change in status.
- Intake: #00087450 - IL-12963-AH/2485-000010-23 - Alleged staff to resident abuse.
- Intake: #00087865 - IL-13128-AH/2485-000011-23 - Alleged staff to resident abuse.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and Wound Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The Licensee failed to ensure that a skin assessment was performed on a resident who returned from hospital.

Rationale and Summary
Upon review of a resident's progress notes and assessments, there was no documentation regarding a skin assessment being performed upon the resident's return from a hospital.

Interview with the DOC confirmed that a head to toe assessment is to be completed upon any leave longer than 24 hours in length and is to be documented in point click care.

Not performing a skin assessment for residents upon return from hospital increases the risk of a delay in identifying and treating impaired skin integrity.

Sources:
The Resident's progress notes and assessments; interviews with the DOC #103, an RN, and other staff.

[000721]

WRITTEN NOTIFICATION: Reports re: Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (a)

The licensee failed to ensure that the hospital was contacted within three business days of a resident being admitted to determine if there was a significant change in condition.

Rationale and Summary
Upon review of a resident's documentation in their medical record, there was no documentation noted that staff of the home contacted the hospital to get an update of the resident's status at any time prior

to the resident returning to the home. Documentation in the resident's medical record also confirmed that the home was aware the resident had a change in condition, as informed by the power of attorney of the resident.

Interview with the Assistant Director of Care (ADOC) confirmed that the home should have contacted the hospital and documented that this occurred.

Not contacting the hospital to determine outcome, may impact the residents plan of care when there is a significant change.

Sources: The resident's medical record, Interview with the ADOC.

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