Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: January 5, 2024	
Inspection Number: 2023-1078-0006	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Starwood, Nepean	
Lead Inspector Severn Brown (740785)	**Inspector Digital Signature**
Additional Inspector(s) Pamela Finnikin (720492)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18, 19, 20, 21, 22, 27, 28, 29, 2023

The following intake(s) were inspected:

- Intake: #00103724 - Proactive Compliance Inspection

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home

Quality Improvement
Pain Management
Falls Prevention and Management
Admission, Absences and Discharge
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
Required information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted as per mandatory postings in the home.

During the initial tour of the home on December 18, 2023, Inspector #720492 observed that the policy to promote zero tolerance of abuse and neglect was not posted at the front entrance in an easily accessible location as per requirements.

On December 19, 2023, Administrator #100 advised the inspector that the policy to promote zero tolerance of abuse and neglect of residents was now on the front entrance board.

Sources: Required information posted at the entrance of the home, policies provided by the home.

[720492]

Date Remedy Implemented: December 19, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the current version of the visitor policy was posted in the home and communicated to residents under section 85 of the Act as

required.

During the initial tour of the home on December 18, 2023, Inspector #720492 observed that the current version of the visitor policy was not posted in the home and communicated to residents as per requirements.

On December 19, 2023, Administrator #100 advised the inspector that the current version of the visitor policy was now posted and available in the front entrance as required.

Sources: Required information posted at the entrance of the home, policies provided by the home.

[720492]

Date Remedy Implemented: December 19, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to be afforded privacy in treatment and in caring for their personal needs was fully respected and promoted by a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW).

Rationale and Summary
During the inspection it was observed by inspector #720492 that an RPN and PSW were providing care for a resident. During the observation the PSW stepped out of the resident's room, and did not close the resident's door or draw the privacy curtain, leaving the resident visible from the hallway during care. During the observation, co-residents, staff members, visitors and the inspector were in the same area of the hallway.

An RPN stated that the PSW stepped out of the room to grab supplies while providing care for the resident. The RPN confirmed that their practice was not appropriate, and that they should have closed the door and drawn the privacy curtain for the resident.

This practice violated the residents' rights to be afforded privacy while receiving personal care, impacting the residents' personal wellbeing.

Sources: Observation of a resident and interviews with an RPN and a PSW #106.

[720492]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20 (b) is on at all times;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that is on at all times.

Rationale and Summary
During an initial tour of the home on December 18, 2023, inspector #720492 observed in a resident room if any RSCRS device was in place in the resident's bedroom and bathroom.

The RSCRS activation station was observed on the wall for both residents in the room. A button on the activation station was observed at a resident's bedside that, when pressed, was not functional. When the inspector notified an RN, they tested the resident's bedside RSCRS device and when pressed, also found it was not functional.

The RN and Administrator confirmed that the RSCRS was not working and required immediate repair.

Failure to ensure that each resident room is equipped with a resident-staff communication and response system that is on at all times posed a potential risk when residents cannot call staff for assistance when required.

Sources:
Observation of a Resident's Room;
Interviews with an RN and the Administrator.

[720492]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that the procedures for the cleaning of positioning aids was complied with. Specifically, the home failed to ensure residents on a unit were provided an exclusive sling for the portable mechanical floor lift. Per O. Reg 246/22 s. 11 (1) b., this procedure must be complied with.

Rationale and Summary
During observations of shared equipment on one unit of the home, a PSW demonstrated to the inspector the cleaning procedure for the unit's portable mechanical floor lift. As part of the observation, the PSW stated that for residents who require a full mechanical lift and require use of the portable mechanical lift, the staff would wipe the sling down with the provided sanitizing wipes when using the sling between residents.

Another PSW, who trains staff members on the use of mechanical lifts in the home, stated that residents require their own exclusive sling and that a sling must be laundered prior to being used for another resident. A different PSW on another unit stated that slings cannot be used between residents and must be sent to laundry for cleaning. The Assistant Director of Care (DOC) stated that residents require their own sling and they must be laundered prior to being used for another resident. Per Policy IC-02-01-11 Cleaning and Disinfecting Equipment, resident care equipment, such as lift slings, must be cleaned and disinfected prior to using with another resident. Policy LP-01-01-04 Mechanical Lifts Roles and Responsibilities, as part of the home's Safe Lifting with Care program, states the there must be an assessment for the potential for cross contamination of equipment and that residents are provided with exclusive use of a sling.

By not ensuring that residents were provided their own sling and that slings were not being laundered between use with different residents, residents are placed at risk of contracting or transmitting a communicable disease.

Sources:
Interviews with three PSWs, and a ADOC;
Observations of floor lift on a unit with a PSW;
Policy LP-01-01-04 Mechanical Lifts Roles and Responsibilities last reviewed March

2023.
Policy IC-02-01-11 Cleaning and Disinfecting Equipment last reviewed October 2020

[740785]

WRITTEN NOTIFICATION: Infection prevention and control

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure compliance with a directive issued by the Director with respect to infection prevention and control. Specifically, the licensee failed to comply with the Assistant Deputy Minister's memorandum to Long-Term Care Licensees, issued November 2, 2023, requiring staff, students, support workers, and volunteers to wear masks when in resident areas indoors.

Rationale and Summary
On December 20, 2023, four staff members were observed in a unit's dining room taking their break. None of the staff members were wearing their masks. Two residents were also present in the dining room during the observation, one of the residents was within six feet of a staff member on break. On December 27, 2023, multiple staff members were observed in the same dining room taking their break. A

resident was also present with the staff members while they were taking their break, all the staff members observed in the dining room were not wearing a mask. The Infection Prevention and Control (IPAC) Lead stated that if staff use the dining room for breaks, then they can only remove their masks to eat and that no residents may be present in the dining room while they are taking their break.

By not ensuring that staff were masked in an indoor resident area, residents were put at risk of contracting a communicable disease.

Sources:
Observations of a dining room on December 20 and 27, 2023;
Interview with the IPAC Lead.

[740785]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The licensee has failed to ensure that controlled substances were stored in a double locked stationary cupboard in the locked medication area.

Rationale and Summary
During observations of the home's controlled substance area on December 22, 2023, the stationary cupboards for the controlled substances in two separate unit's medication rooms were observed to only be single locked when not in use. On December 27, 2023, the narcotics drawer in one unit's medication room was observed to only be single locked. An RN stated that the controlled substance storage area must be double locked when not being used. The IPAC Manager stated that the controlled substance storage area must be double locked when not being used.

By not ensuring that the controlled substances storage areas were not double locked, there was risk of inappropriate access to controlled substances.

Sources:
Observations of two different medication room on December 22, 2023. Observation of a medication room on December 22 and 27, 2023;
Interviews with an RN and the IPAC Manager.

[740785]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 3.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
3. That drugs are destroyed and disposed of in a safe and environmentally

appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The licensee has failed to ensure compliance with the home's policy for drug destruction and disposal. Specifically, the licensee failed to ensure that controlled substances were destroyed and disposed of in an environmentally appropriate manner as per the home's policy: Management of Insulin, Narcotics, and Controlled Drugs. Per O. Reg 246/22 s. 11 (1) b., the licensee must comply with their policy.

Rationale and Summary
On December 22, 2023, during observations of the destruction and disposal of controlled substances, in two separate medication rooms for different units, both RNs demonstrating controlled substance destruction stated that after controlled substances were denatured, that the medication would be poured down the sink with a witness. The IPAC Manager stated that controlled substances must be disposed of in the medication disposal container after being denatured. Policy RC-16-01-13 Management of insulin, narcotics, and controlled drugs, states that, for on-site Narcotic and controlled drug destruction, the denatured narcotic or controlled substance will be transferred to the designated medication waste container.

By not ensuring that controlled substances were disposed of in an environmentally appropriate manner, the licensee risked environmental contamination with controlled substances.

Sources:
Observation of two medication rooms on different units on December 22, 2023;
Interviews with two RNs and the IPAC Manager;

Policy RC-16-01-13 Management of Insulin, Narcotics, and Controlled drugs, last reviewed January 2022.

[740785]