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**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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# Original Public Report

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| **Report Issue Date:** May 1, 2024 |
| **Inspection Number:** 2024-1078-0001 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **Licensee:** Extendicare (Canada) Inc. |
| **Long Term Care Home and City:** Extendicare Starwood, Nepean |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Dee Colborne (000721) | Diana (Dee) Colborne<br>Digitally signed by Diana (Dee) Colborne<br>Date: 2024.05.02 16:09:35 -04'00' |

**Additional Inspector(s)**

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 18, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00108694 -Fall of resident resulting in a significant injury.
- Intake: #00112356 -Death of a resident related to an incident.
- Intake: #00113668 -Complaint regarding a death of a resident related to an incident.

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

Resident Care and Support Services
Infection Prevention and Control

Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (7)**

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. Specifically, staff did not comply with the written plan of care for a resident, which resulted in a resident having a fall that resulted in significant injury.

**Rationale and Summary:**

Upon review of a resident's written plan of care, it states that the resident is not to be left unsupervised when in their wheelchair in their bedroom or in the dining room and is to be placed at the nursing station when awake.

Upon review of a resident's progress notes, on a specified date in February 2024, a resident sustained a fall that resulted in them being transferred to hospital and as a result sustained a significant injury.

Review of a resident's post fall assessment completed on a specified date in February 2024, identified that a resident was left sitting in their wheelchair by

themselves in their room.

On a specified date in April, 2024, during the inspector's initial tour of the home, the inspector observed the resident in their specific wheelchair in their room beside the bed unsupervised.

Interview with a personal support worker (PSW) confirmed that the resident was not to be left in their wheelchair in their room and confirmed that they were left in their wheelchair in their room the day of the fall.

Interview with the Assistant Director of Care (ADOC), confirmed that the written plan of care for the resident is that they are not to be left sitting in their wheelchair in their room unattended and that this contributed to the resident's fall on a specified date in February 2024, and this continues to be in the written plan of care.

Failure to comply with the written plan of care, increases the risk to residents for further injury.

**Sources:** A resident's written plan of care, progress notes, post falls assessment, inspector observations, interviews with ADOC, a PSW, and other staff.
[000721]