Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Dec 16, 19, 2011; Jan 30, Feb 1, 2, 2012	2011_036126_0049	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator,one Registered Nurse and one Registered Practical Nurse

During the course of the inspection, the inspector(s) review the residents health care records and observed care and services provided to two specific resident

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

An identified resident,was demonstrating responsive behavior and was exhibiting aggressive behaviors between the period of October 2011 and December 2011.

As per the documentation in the progress note, it is noted that in those months an identified resident was aggressive:

In October, 2011:
-Intra Muscular Haldol given because resident refused to take po medications and was presenting with aggressive behavior.
-Resident was physically aggressive around supper and tried to push another resident from the back and hit a Personal support Worker(PSW) and writer on their upper arms.
-Resident was being aggressive to PSW when the PSW was trying to give evening care to another resident."
-Resident was being physically aggressive ie. pushing and hitting out a PSW while PSW was trying to provide care to other resident.
-Resident hit another resident in her/his right upper shoulder around lunch time. No bruising noted.

In November 2011:
-Resident was very aggressive with staff
-Resident got agitated , verbally abusive and tried to struck another resident. Medication given with good effect.
-Resident threw a cup of tea to a Health Care Aide(HCA) in the afternoon in hallway at nurses station.

In December 2011
-Resident kicked a chair and punch a resident on the mouth.No injury noted.

The licensee has failed to ensure that further action was taken to meet an identified resident needs in response to her/his aggressive behaviors including an assessment such as a referral to specialized resources. s.53.(4) c

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Issued on this 2nd day of February, 2012

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