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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Public Report

Report Issue Date: May 12, 2025
Inspection Number: 2025-1078-0005
Inspection Type: Complaint Critical Incident
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Starwood, Nepean

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30, 2025 and May 1, 2, 5, 6, 8, and 9, 2025

The following intake(s) were inspected:

- Intake: #00142779 - complaint with concerns related to care being provided to residents by staff.
- Intake: #00144715 - related to a resident's fall resulting in a significant change in the resident's condition.
- Intake: #00144793 - related to a resident's fall resulting in a significant change in the resident's condition.
- Intake: #00146745 - related to a resident's improper/incompetent care related to transfers.

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

Continence Care
Resident Care and Support Services
Prevention of Abuse and Neglect

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. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care related to falls prevention was revised when the care set out in the plan was no longer necessary.

A Resident's plan of care included the use of a falls prevention intervention, but was not observed by the inspector to be in place as required.

During an interview, the Director of Care (DOC) indicated that the resident did not actually require the use of this falls prevention intervention.

Sources: inspector's observation, a review of the resident's health care records,

including care plan and progress notes, and interviews with staff, including DOC.

During the inspection, the resident's plan of care was updated, and was found to no longer include the indicated falls prevention intervention prior to the conclusion of the inspection.

Date Remedy Implemented: May 5, 2025

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect that improper care of a resident had resulted in harm to the resident, the suspicion and the information upon which it was based was reported to the Director.

During an interview, a resident alleged that a recent significant change in their health status had occurred during a transfer performed by staff of the long-term care home, and was not the result of a fall. The Director of Care (DOC) indicated that they had initiated an investigation immediately, at which time the resident made the same allegations during a separate interview.

The allegation was not reported to the Director under the Fixing Long-term Care

Home Act (FLTCA), 2021, until approximately five days after members of the long-term care home's leadership team were made aware.

Sources: a review of relevant records, including a related critical incident report and interview with the resident and staff, including Personal Support Worker (PSW) and DOC.

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a resident fell, the required post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that policies and protocols of the falls prevention and management program were complied with.

Specifically, staff failed to comply with policy titled *Neurological Signs/Head Injury Routine* (Last reviewed March, 2025), and policy titled *Falls Prevention and Management* (Last reviewed March, 2025) when they failed to complete a head injury routine after the resident experienced an unwitnessed fall.

Sources: resident's relevant health care records including progress notes, post-fall assessments, medication administration record (MAR) and related risk management report; the licensee's policies titled *Falls Prevention and Management* (last reviewed March, 2025) and related Appendices, including the Post Fall Clinical Pathway (Appendix 5) and Clinical Monitoring Record (Parts A and B), and policy titled *Neurological Signs/Head Injury Routine* (last reviewed March, 2025); and interviews with staff, including PSW, the DOC and the Administrator.