Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 8, 2013 | 2013_128138_0038 | O-000363-13 | Critical Incident System |

**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**

PAULA MACDONALD (138)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): October 1 and 2, 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), and several Personal Support Workers (PSW).**

**During the course of the inspection, the inspector(s) reviewed several Critical Incident Reports (CIR), reviewed several resident health care records, and reviewed the homes policies on falls and falls management.**

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

**Personal Support Services**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.)<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6. (1) (c) in that the licensee failed to ensure that there was a written plan of care for a resident that sets out clear direction to staff who provide direct care to the resident.

The Ministry of Health and Long Term Care received a Critical Incident Report (CIR) that outlined Resident #1 suffered an injury that was identified after staff completed a transfer on a specified date in May 2013. The CIR indicated that the cause of the injury was unknown but that there was the possibility that the resident's own movement may have been a contributing factor to the injury. The CIR also indicated that the resident has had past experiences where his/her movement had affected transfers.

Long Term Care Homes Inspector #138 spoke with PSW #1 who was present during the transfer in May 2013. PSW #1 stated that at the time of the incident the resident was transferred via a two person transfer from his/her wheelchair to his/her bed and further stated that s/he was unaware of any injury to the resident until the resident had been placed in his/her bed. PSW #1 stated that s/he was unsure how the injury occurred. S/he also stated that the resident could be unpredictable in his/her ability to complete a transfer. PSW #1 was not able to confirm if the resident experienced any instability in completing the two person transfer during the incident in May 2013.

Long Term Care Homes Inspector also spoke with another personal support worker, PSW #2, who reported that s/he was familiar with the care of Resident #1 when the incident occurred. PSW #2 also stated that Resident #1 can be unpredictable with his/her ability to complete a two person transfer.

The resident's health care record was reviewed. The plan of care that was in effect when the resident sustained the injury in May 2013, indicated that the resident was to be transferred via extensive assistance with two staff to transfer and that the resident assists in transfers with partial weight bearing. The care plan did not set out clear direction to staff as to Resident #1's unpredictability to weight bear and complete a two person transfer. [s. 6. (1) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care for Resident #1 sets out clear direction for staff with respect to the resident's transfers, to be implemented voluntarily.***

**Issued on this 8th day of October, 2013**

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

Lynn Duchesne RN #117 for
Paula MacDonald RD #138