



**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
Direction de l'amélioration de la
performance et de la conformité**

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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
Aug 27, 2013	2013_200148_0028	O-000682- 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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 25, 2013, on site

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Clinical Supervisor, Physician, Registered Nursing Staff and Personal Support Workers.

During the course of the inspection, the inspector(s) resident health records including flow sheets, plans of care and medication administration. In addition documents related to the monitoring of responsive behaviours including Policy #09-05-01 were reviewed and a letter of discharge. The inspector also observed staff-resident interaction and resident care.

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



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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 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 :



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1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6(1)(a), whereby the licensee did not ensure that the written plan of care for each resident sets out the planned care for the resident.

A review of Resident #1's health care record indicated particulars related to the resident's sleeping pattern. The health care record further demonstrates that the resident's sleeping pattern affects several areas of care. Staff interviews and documentation indicated that the management of Resident #1's sleep patterns vary and produce various outcomes related to the resident's mood/behaviour. The written plan of care does not set out the planned care for the above affected care areas and the strategies that are implemented by staff.

Staff interviews indicate that as part of the strategies to manage Resident #1's behaviours a reward system is in place. This planned care is not set out in the current plan of care for Resident #1. [s. 6. (1) (a)]

Issued on this 27th day of August, 2013

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

Amanda Alexi RD LTCH Inspector