Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2019	2019_717531_0015	002247-18, 003522-18, 005253-18, 008043-18, 009510-18, 010952-18, 012664-18, 013349-18, 020209-18, 020242-18, 023927-18, 009248-19, 009818-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Guildwood
60 Guildwood Parkway SCARBOROUGH ON M1E 1N9

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

SUSAN DONNAN (531), EMILY BROOKS (732), HEATH HEFFERNAN (622), LINDA HARKINS (126), LYNE DUCHESNE (117)

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): June 10, 11, 12, 13, 17, 18 and 19, 2019

T he following intake logs where completed concurrently during this inspection :
Log #002247-18 related to fall prevention
Log #003522-18 related to fall prevention
Log #005253-18 related to safe and secure home
Log #008043-18 related to fall prevention
Log #009510-18 related to alleged staff to resident abuse
Log #010952-18 related to alleged resident to resident abuse
Log #012664-18 related to personal support services
Log #013349-18 related to fall prevention
Log #020209-18 related to responsive behaviour
Log #023927-18 related to responsive behaviour
Log #009248-19 related to personal support services
Log #009818-19 related to responsive behaviour

During the course of the inspection, the inspector(s) spoke with the two Directors of Care (DOC), the Environmental Services Supervisor (ESS), a Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Administrative Clerk, a Housekeeping Aide (HA), resident Substitute Decision Maker (SDM) and residents.
During the course of the inspection, the inspectors conducted a walking tour of the home, observed resident care and services, reviewed resident health care records, reviewed the abuse and neglect policy and procedures and the falls prevention policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 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 ensure that there is a written plan of care for resident #017 that sets out clear directions indicating that the resident was not to be left on the toilet unattended.

Critical Incident System report (CIS) #2164-000008-18 on a specified date indicated that resident #017 had been placed on the toilet and left unattended resulting in a fall. Resident #017 sustained a small laceration which required two sutures.

On June 13, 2019, Inspector #622 reviewed the plan of care on Point Click Care (PCC) for the specified date which was current at the time of the fall for resident #017 . The care plan did not include direction that resident #017 was not to be left unattended on the toilet.

During an interview with inspector #622 on June 17, 2019, Director of Care (DOC) #108 stated that the care plan highlighted and identified the falls prevention interventions. Inspector #622 and DOC #108 reviewed the care plan for resident #017 for the specified date which did not include direction that resident #017 was not to be left unattended on the toilet. DOC #108 indicated that the plan of care did not provide clear directions to the staff who cared for resident #017 at the time of the fall. [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 that the written plan of care provides clear direction to staff and others who provide care to the resident, to be implemented voluntarily.

Issued on this 9th day of July, 2019

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

Original report signed by the inspector.