Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 17, 2021	2021_838760_0004 (A1)	014932-20, 019451-20	Complaint

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Resident numbers corrected.

Issued on this 17th day of February, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 29, February 1, 10, 11, 2021 (conducted on-site); February 2, 3, 2021 (conducted off-site).

The following intakes were completed in this complaints inspection:

A log was related to medication;

A follow up log to Compliance Order (CO) #001, s. 6. (4), related to plan of care, issued under inspection #2020_748653_0013, on July 15, 2020, with a compliance date of November 30, 2020, was inspected.

A Critical Incident Systems inspection #2021_838760_0005 was conducted concurrently with this Complaints inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Activity Aides, Environmental Services Manager (ESM), Registered Dietitian (RD), Physician and the Director of Care (DOC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2020_748653_0013	760

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001's plan of care was documented.

The Ministry of Long-Term Care was informed of concerns related to how the resident did not receive an intervention prior to their passing. A review of the resident's chart did not produce any documented information on the resident's status. The progress notes had indicated that the resident developed symptoms but their exact status was not documented. An interview with an RPN, stated they remembered that they had assessed the resident's status prior to their passing but did not document this on the resident's chart. An RN, who worked on the shift after the RPN, stated they had applied an intervention for the resident, however, this was not effective and the resident passed away shortly after. The RN did not recall getting report or reviewing any documentation related to the resident's status. There was potential risk to the resident, as the documentation of the resident's exact status prior to their passing could have been beneficial for the nurses to determine whether the resident had required the intervention prior to their passing.

Sources: Resident's chart, progress notes; Interviews with an RPN, an RN and other staff. [s. 6. (9) 1.]

Issued on this 17th day of February, 2021 (A1)

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

Original report signed by the inspector.