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

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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
Aug 17, 2021	2021_875501_0017	003604-21, 009875-21	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

SUSAN SEMEREDY (501), VERON ASH (535)

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): July 19, 20, 21, 22, 2021.

The following intakes were inspected during this complaint inspection:
Log #003604-21 related to responsive behaviours; and,
Log #009875-21 related to a follow up to Compliance Order #001 from inspection #2021_595110_0006 regarding the prevention of abuse and neglect with a compliance due date of June 30, 2021.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care/Infection Prevention and Control (IPAC) Lead, Registered Nurses from Ontario Shores (Behaviour Therapist and Community Nurse Clinician), Building Services Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), recreation staff, Behaviour Support Ontario (BSO) RPN, and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, IPAC practices and reviewed clinical health records, relevant home policies and procedures, room temperature logs, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 19. (1)	CO #001	2021_595110_0006	535

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to a resident as specified in the plan.

A resident was known to have responsive behaviours and according to BSO RPN was to have an intervention. An observation indicated the resident was not being provided this intervention. Interviews with the BSO RPN and the DOC acknowledged that the resident should have been receiving such intervention.

Failing to provide the resident with interventions for their responsive behaviours puts other residents at risk.

Sources: Observation, the resident's medical record and interviews with BSO RPN and the DOC. [s. 6. (7)]

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 plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

A resident was known to have responsive behaviours towards others and was found in another resident's room where an altercation occurred. The incident was not reported to the Director. A previous manager was documented as having communicated that a report to the Director was not necessary. The current DOC confirmed this incident should have been immediately reported.

Failing to report incidents of resident abuse to the Director puts residents at risk for further possible harm.

Sources: A resident's medical record and interviews with a resident and the DOC. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not restrained by the use of barriers from entering a part of the home generally accessible to other residents.

A resident was known to have responsive behaviours. Observations indicated the resident was prevented from entering parts of the home due to barriers created by staff. As well hallways were closed preventing other residents from going to other parts of the home. Interviews with BSO RPN and the DOC indicated they were aware of the above noted interventions.

Creating barriers to prevent residents from freedom of movement is an improper restraint.

Sources: Observations, a resident's medical record and interviews with consultants, BSO RPN and other staff. [s. 30. (1) 5.]

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 residents are not restrained by the use of barriers from entering a part of the home generally accessible to other residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that temperatures were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the home's Temperature and Humidity Logs indicated the home was monitoring and documenting room temperatures once every morning and afternoon but only started monitoring and documenting temperatures every evening or night starting July 6, 2021. During an interview the Building Services Manager indicated they were aware that temperatures had to be monitored and documented three times a day which included every evening or night since May 15, 2021, but that implementing this was at first difficult.

Failing to measure and document temperatures in the home puts residents at risk for heat related illness.

Sources: The home's Temperature and Humidity Logs from June 6, 2021 to July 18, 2021 and an interview with the Building Services Manager. [s. 21. (3)]

Issued on this 25th day of August, 2021

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

Original report signed by the inspector.