Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 30, 2024

Inspection Number: 2024-1054-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Guildwood, Scarborough

Lead Inspector	**Inspector Digital Signature**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2024.01.31 15:51:37 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 10-12, 15-16, 18-19, 22, 2024
The inspection occurred offsite on the following date(s): January 23, 2024

The following Complaint intake(s) were inspected:
• Intake: #00105887 - Complaint related to falls resulting in injury, alleged improper care, laundry and maintenance services

The following Critical Incident (CI) Intake(s) were inspected:
• Intake: #00097384 – CI 2164-000015-23 related to conduct that resulted in harm/risk of harm to a resident
• Intake: #00106140 – CI 2164-000003-24 related to a disease outbreak

The following intakes were completed in this inspection: Intake: #00099721 – CI 2164-000019-23, Intake: #00101046 – CI 2164-000021-23, Intake: #00104508 – CI 2164-000022-

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

23, Intake: #00105250 – CI 2164-000024-23 and Intake: #00105751 – CI 2164-000002-24 were related to falls.

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer

necessary

The licensee has failed to ensure a resident's care plan was revised when an intervention was no longer applicable.

Rationale and Summary
A resident's care plan indicated an intervention to be provided to reduce the risk of injury from a fall.

A progress note, indicated that staff spoke with the resident's substitute decision-maker (SDM) about the resident's refusal for the application of the intervention, and that the SDM gave their approval to discontinue it.

A Registered Practical Nurse (RPN) confirmed that after the conversation with the SDM, the intervention was no longer provided. A Personal Support Worker (PSW) confirmed the intervention was no longer provided.

The resident's care plan was not updated to reflect this change until several months later. The Director of Care (DOC) confirmed the update should have been made immediately after the conversation with the SDM.

Sources: Resident's clinical records, Interviews with a PSW, RPN and the DOC. [741725]

Date Remedy Implemented: January 19, 2024

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that the pain management program to identify and manage pain in residents was implemented when a resident initially had a fall and later returned from hospital.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies and protocols developed for the pain management program were complied with.

Specifically, staff did not comply with the long-term care home's (LTCH) policy for pain identification and management which was included in the licensee's Pain Management program.

Rationale and Summary
A resident's progress notes indicated they had a fall. During a post-fall assessment, the resident indicated they felt pain. The resident was transferred to the hospital on the same day. They returned to the LTCH with altered skin integrity related to a procedure. The resident's medication administration record (MAR) indicated a new order was made for pain medication related to the procedure. After returning to the LTCH, the resident continued to exhibit pain.

The LTCH's policy for pain identification and management indicated that all residents would have a comprehensive pain assessment with any new pain, upon return from hospital or when a new pain medication was started.

After reviewing the resident's clinical records, the DOC noted a comprehensive pain assessment was not completed for the resident until one week after returning to the LTCH. They indicated this did not meet the LTCH's expectations.

Failing to complete a comprehensive pain assessment when the resident had a fall, and upon return from hospital with a new order for pain medication, placed the resident at risk for unmanaged pain. The LTCH also missed an opportunity to establish a baseline for continued pain monitoring.

Sources: Resident's clinical records, pain identification and management policy, Interview with the DOC. [741725]

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure a resident was assessed by a Registered Dietitian (RD) when they returned to the LTCH from another facility with altered skin integrity related to a procedure.

Rationale and Summary

The resident's progress notes indicated the resident returned to the LTCH with altered skin integrity related to a procedure.

An RPN and the DOC confirmed that an RD referral was not made upon the resident's return to the LTCH. As a result an RD assessment was not completed.

Failing to have the resident assessed by an RD when they had altered skin integrity related to a procedure resulted in the resident not being offered additional nutritional support for wound healing.

Sources: Resident's clinical records, Interview with RPN, Email from DOC. [741725]

WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances were kept inaccessible to residents at all times, when a housekeeping cart in use did not have a working lock.

Rationale and Summary
A housekeeping cart was observed in a resident home area (RHA) with residents in the vicinity. The housekeeping cart was found to contain cleaning products in an unlocked compartment. The label on a cleaning product indicated the product could cause moderate irritation to eyes, mild irritation to skin, and to call a physician

or poison control if ingested.

An Environmental Service Aid (ESA) confirmed the housekeeping cart lock was broken and indicated they had reported the issue to the previous Support Service Manager (SSM). The current SSM indicated they started their position six months ago, and acknowledged they were aware that the housekeeping cart's lock was broken. They also confirmed hazardous cleaning products were stored in the unlocked compartment and were a risk to resident safety.

After the interview, on the same day, the ESM and current SSM showed the Inspector that the lock was replaced on the housekeeping cart.

Failing to replace the broken lock on the housekeeping cart for several months placed residents at risk for potential negative health outcomes.

Sources: Observations, cleaning product label, Interviews with an ESA and SSM. [741725]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms of an infection were

recorded for two residents.

Rationale and Summary
Two residents began displaying symptoms of infection on two different days. They were both tested and remained on isolation for a specific period of time. During this period of time, the LTCH failed to record their symptoms of infection every shift, on multiple occasions.

The IPAC lead indicated both residents should have had their symptoms recorded in their progress notes and in a daily 24-hour symptom surveillance form every shift. They acknowledged ongoing issues with nursing staff completing these documentation requirements.

Failing to record symptoms every shift for both residents showing symptoms of an infection placed them at risk for a potential delayed response to a worsening condition.

Sources: Residents' clinical records, daily 24-hour symptom surveillance forms, Interview with IPAC lead. [741725]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease

as defined in the Health Protection and Promotion Act.

The licensee has failed to immediately report a disease outbreak to the Director.

Rationale and Summary
In an email correspondence on a specific date, Toronto Public Health (TPH) informed the LTCH that a confirmed disease outbreak on a specific unit would be declared that day and assigned an outbreak number.

A Critical Incident System (CIS) report related to the disease outbreak was submitted to the Director the next day.

The DOC acknowledged the CIS report was submitted one day late.

Failing to immediately report the disease outbreak to the Director had no impact or risk to residents.

Sources: CIS report, Email correspondence between the LTCH and TPH, Interview with the DOC. [741725]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and

Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall
1.Educate an ESA on the LTCH's policy of designated areas for eating and drinking. Keep a documented record of contents of education provided, name of who received and provided the education, date education was provided.

2.Develop a process to ensure an outbreak notification sign is posted and remains on the LTCH's entrance door for the duration of an outbreak, if directed by the local public health unit. Keep a documented record of the process and date when it was created.

3.Develop an active screening tool and process to be used by the LTCH, if directed by the local public health unit. Keep a documented record of the tool and process and date when it was created.

4.Educate nursing staff on a specific unit on the LTCH's policy related to reporting infections to the Infection Prevention and Control (IPAC) lead. Keep a documented record of contents of education provided, names of who received and who provided the education, date education was provided.

5.Educate the IPAC lead and DOC on case definitions for confirmed and suspected outbreaks related to a specific type of infection. Keep a documented record of contents of education provided, name of who received and provided the education, date education was provided.

Grounds
The licensee has failed to ensure all staff participated in the implementation of the home's IPAC program.

Rationale and Summary
1) An ESA was observed having a drink in the hallway of a unit that was affected by a disease outbreak.

The ESA acknowledged they were aware of the home's policy of not drinking in the RHA for reasons of infection control.

The IPAC lead also confirmed that environmental controls were a part of the home's IPAC program, and that staff drinking in the hallway of an outbreak unit could expose residents to a risk of disease transmission. They stated the behaviour was clearly against the home's policy.

Failing to ensure the ESA participated in the environmental controls determined for the home placed residents at risk for infection exposure and for a prolonged outbreak.

Sources: Observations, Interviews with the ESA and IPAC lead. [741725]

2) On a specific date, TPH declared a confirmed disease outbreak in the LTCH.

TPH's confirmed respiratory outbreak management checklist, indicated outbreak notification signs needed to be posted at all entrances to the facility and affected areas. This form was signed and dated by the LTCH's IPAC lead.

The LTCH's policy on declaring an outbreak, located in the LTCH's IPAC Manual,

indicated that when a public health authority declared an official outbreak in the home, staff would take preventative measures and follow specific public health authority directives to stop the spread of infection, and that all measures must be put in place to prevent the spread of infection.

The IPAC lead indicated they had posted an outbreak notification sign on the LTCH's front door, however, that it had unknowingly been removed.

The Inspector observed the outbreak notification sign re-posted on the LTCH front door on a specific date.

Failing to implement a layer of protection directed by TPH, placed the residents at increased risk for disease exposure.

Sources: LTCH's policy on declaring an outbreak, TPH's confirmed respiratory outbreak management checklist, Interviews with IPAC lead. [741725]

3) On a specific date, TPH declared a confirmed disease outbreak in the LTCH.

TPH's confirmed respiratory outbreak management checklist indicated staff and visitors were to conduct active screening prior to working in or visiting an outbreak unit. This form was signed and dated by the LTCH's IPAC lead.

The LTCH's policy on declaring an outbreak, located in the LTCH's IPAC Manual, indicated that when a public health authority declared an official outbreak in the home, staff would take preventative measures and follow specific public health authority directives to stop the spread of infection, and that all measures must be put in place to prevent the spread of infection.

A PSW and RPN, both indicated they worked on an outbreak unit and did not conduct active screening before starting their shift. The IPAC lead confirmed the LTCH had not been requiring staff and visitors to conduct active screening before working on or visiting an outbreak unit since the start of the outbreak.

Failing to implement a layer of protection directed by TPH, placed the residents at increased risk for disease exposure.

Sources: LTCH's policy on declaring an outbreak, TPH's confirmed respiratory outbreak management checklist, Interviews with a PSW, RPN and the IPAC lead. [741725]

4) A resident's progress notes indicated that on a specific date, they presented with symptoms of an infection and a test was performed. Four days later, the resident's progress note indicated that the resident remained on isolation and that the IPAC lead was notified.

On the daily 24-hour symptom surveillance form, the resident's symptoms were first documented four days after they initially presented.

The LTCH's policy on reporting infections, located in the LTCH's IPAC Manual, indicated that a daily 24-hour symptom surveillance form was used to communicate symptoms of possible communicable diseases. The policy also indicated that staff were to inform the IPAC lead/designate upon observing a resident displaying symptoms that suggest an infection.

The IPAC lead confirmed they reviewed the daily 24-hour symptom surveillance form each day and required nursing staff to complete it in a timely manner. They also confirmed they were first informed of the resident's symptoms of infection four

days after their onset.

Failing to inform the IPAC lead immediately upon observing a resident displaying symptoms suggesting an infection placed other residents at risk for disease exposure and illness.

Sources: Resident's clinical records, daily 24-hour symptom surveillance forms, reporting infections, Interview with IPAC lead. [741725]

5) On a specific date, the IPAC lead emailed TPH for the first time, to inform them of cases of respiratory illness in the LTCH. In a later email to TPH, the IPAC lead indicated that the case definition for a confirmed respiratory infection outbreak that included three cases of acute respiratory illness (ARI) (lab confirmation not necessary) occurring within 48 hours with any common epidemiological link (eg. unit) had been met. That same day, TPH declared a confirmed disease outbreak in the LTCH.

According to the outbreak line list, on a specific date, two residents on a specific unit presented with symptoms of a respiratory infection. Two days later, eight additional residents in the same unit presented with symptoms of a respiratory infection.

The IPAC lead and DOC explained TPH was not contacted that day as DOC assessed residents who became symptomatic on that day, and concluded that the symptoms were related to a chronic medical condition.

The LTCH's policy on influenza and ARI, located in the LTCH's IPAC Manual, indicated the importance of taking immediate action to protect residents from these infections, as they could quickly spread. According to the LTCH's procedures, the IPAC lead/designate was expected to report to the local public health authority if

there was more than one case displaying respiratory symptoms.

The LTCH's policy on declaring an outbreak located in the LTCH's IPAC Manual, indicated the IPAC lead/designate and the DOC must be aware of the case definitions and declare an outbreak when symptoms meet the criteria. The IPAC lead/designate is also directed to immediately inform the local public health authority of a suspected outbreak.

The DOC acknowledged that in retrospect, TPH should have been informed of the respiratory illnesses when the additional eight residents presented with symptoms. They indicated if an outbreak was not caught at the beginning, the infection could easily spread because of the congregated setting of the LTCH.

Failing to immediately report cases of a respiratory illness to TPH resulted in a delay of protective IPAC measures being implemented, and a more widespread outbreak that included additional residents and staff.

Sources: Line list, email correspondences between LTCH and TPH, declaring an outbreak and influenza and ARI policies, Interviews with IPAC lead and DOC. [741725]

This order must be complied with by April 3, 2024

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #001 issued to O.Reg. 246/22, s. 102 (8) in 2022-1054-0001 on May 11, 2022

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the

licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.