Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5

Original Public Report

Report Issue Date: March 21, 2024	
Inspection Number: 2024-1054-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Guildwood, Scarborough	
Lead Inspector Susan Semeredy (501)	**Inspector Digital Signature**
Additional Inspector(s) Henry Chong (740836)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6-8, 11-15, 2024

The following intake(s) were inspected:

- Intake: #00110529 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management

Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
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: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that as part of the organized program of housekeeping, the licensee's procedures were followed for cleaning and

disinfection of contact surfaces, using at a minimum a low-level disinfectant.

Rationale and Summary
On March 6, 2024, one bottle of expired low-level disinfectant used to clean and disinfect contact surfaces was observed in a housekeeping supply room. A housekeeper removed the expired product immediately and stated that the product should not be used. Infection Prevention and Control (IPAC) Manager confirmed that the product should not have been in use and that it had been replaced.

The use of expired low-level disinfectant to clean and disinfect contact surfaces increased the risk of infection transmission in the home.

Sources: Inspector's observations and interviews with a housekeeper and the IPAC Manager. [740836]

Date Remedy Implemented: March 6, 2024

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that a resident's right to be treated with courtesy and respect was fully respected and promoted.

Rationale and Summary
A resident indicated they did not feel they were treated with courtesy and respect when a Personal Support Worker (PSW) assisted them with an Activity of Daily Living (ADL). The home's complaint investigation form indicated the PSW admitted to inappropriately providing assistance.

A Director of Care (DOC) confirmed that the PSW did not treat the resident with respect and dignity by being task focused and not taking into account how the resident felt.

Failing to treat the resident with respect risked diminishing their sense of well-being, dignity and self-worth.

Sources: The home's complaint investigation form and interviews with a resident, a DOC and other staff. [501]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident's plan of care indicated that staff were to apply an assistive device to prevent skin breakdown. On two different days the assistive device was not applied.

As well, the resident was not taken to the dining room for a meal. A PSW admitted they did not review the resident's plan of care.

A DOC confirmed there was nothing in the resident's plan of care to indicate the resident was to receive meals in their room and also acknowledged that the assistive device should have been provided.

Failing to provide the care set out in the plan of care put the resident at risk for possible skin breakdown and social isolation.

Sources: Observations, a resident's plan of care and interviews with a DOC and other staff. [501]

WRITTEN NOTIFICATION: Reporting and complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by two PSWs that resulted in a risk of harm to the

resident was immediately reported to the Director.

Rationale and Summary
A resident indicated that they were abused by two PSWs by being treated roughly causing them pain.

The home's investigation notes indicated the resident reported the above incident and stated they were fearful. The investigation commenced immediately but the allegations were unsubstantiated.

A DOC acknowledged that even though the home's investigation could not substantiate the resident's allegations, the home should have reported the incident immediately to the Director.

Failing to report a suspicion of abuse puts residents at risk for continued mistreatment.

Sources: The home's investigation notes and interviews with a resident and a DOC. [501]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 21.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

21. Sleep patterns and preferences.

The licensee has failed to ensure a resident's plan of care was based on an interdisciplinary assessment with respect to their sleep patterns and preferences.

Rationale and Summary
A resident indicated that they would like to sleep in. The resident's plan of care did not include sleep patterns and preferences. A DOC indicated they were aware the resident was not a morning person and that their preference to sleep in should be included in their plan of care.

Failing to assess a resident's sleeping preferences put the resident at risk for a reduced quality of life.

Sources: A resident's plan of care and interviews with the resident and a DOC. [501]

WRITTEN NOTIFICATION: Menu planning

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee has failed to ensure that a resident was offered a between-meal beverage.

Rationale and Summary
A covered beverage was sitting on a resident's dresser with a clean plastic spoon beside the glass. A DOC also made this observation and confirmed this beverage should have been given to the resident between meals.

Failing to ensure the resident was offered a between-meal beverage put them at risk for dehydration.

Sources: Observation and interviews and DOC other staff. [501]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The licensee has failed to ensure that all foods in the food production system were served using methods to prevent food borne illness.

Rationale and Summary
During a meal service, a dietary aide documented the desserts as being at 40 degrees Fahrenheit without taking their temperature or being aware they had

arrived to serving area. When they did take the temperatures of the pureed, minced and regular textured fruit at the time of service, they were 56, 57 and 58 degrees Fahrenheit respectively. Review of the temperature logs for this dining room for three previous days, indicated all cold food was at 40 degrees Fahrenheit. The dietary aide confirmed they do not take the temperatures of the cold food.

The home's policy "Holding and Distribution of Food" NC-07-01-02 last reviewed January 2022 indicated that dietary will distribute and hold food in a manner that maintains the temperature. Cold foods were to be held at a temperature below 40 degrees Fahrenheit.

The Food and Nutrition Manager (FNM) acknowledged the dietary staff were not taking the temperature of the cold food according to the policy which could pose a risk of food borne illness.

Failing to take the temperatures of food at the point of service put residents at risk for food borne illness.

Sources: Observation, food temperature logs, the home's policy and interviews with a dietary aide and the FSM. [501]

WRITTEN NOTIFICATION: Dining and snack service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

The licensee has failed to comply with the process to ensure that food service workers and other staff assisting residents were aware of special needs and preferences for resident #001 and #002.

Rationale and Summary
In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that the dining and snack service includes a process to ensure food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and must be complied with.

Specifically, staff did not comply with the policy "Meal Service and Dining Experience" NC-03-01-01 last reviewed November 2023, which indicated dietary aides were to refer to a diet list when plating meals. As well, according to the Food and Nutrition Manager (FNM), nursing staff were to refer to the fluid list when serving beverages in the dining room and this list was to be updated by the dietary team.

During a meal service it was observed that the dietary aide, as well as the nursing staff, were not referring to the diet and fluid lists. Resident #001 was served a specific type of meat entrée and according to the diet list and the resident's care plan, they did not like to eat this type of meat. Resident #002 was served three beverages with their meal and according to the resident's care plan, the resident was on a fluid restricted diet and was only to receive two beverages. The fluid list available to nursing staff was not used and the nursing staff were unaware of a fluid restriction. A review of the fluid list did not indicate resident #002 was on a fluid restriction. This also occurred on another day, when they were served an extra

beverage. The fluid list had still not been updated and the nursing staff continued to be unaware of the restriction.

Staff also did not comply with the policy “Meal Service and Dining Experience” that indicated residents in the dining room were to be seated according to the established seating plan. According to the seating plan, resident #001 was to be served in the larger dining room but was seated in the smaller dining room. As well resident #002 was to be served in the smaller dining room but was seated in the larger dining room.

The FNM acknowledged there were seating plans and lists for fluids and diets, but they were not up to date, and the staff were not using them according to the home’s policy.

Failing to follow the home’s policy to ensure food service workers and other staff assisting residents are aware of the residents’ diets, special needs and preferences put residents at nutritional risk.

Sources: Observations, the home’s policy and interviews with the FNM and other staff. [501]

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure proper techniques were used when a PSW assisted a resident with eating.

Rationale and Summary
A PSW was observed standing while feeding a resident in bed. The resident's head of the bed was not upright.

The resident required total assistance with eating related to physical limitations and had chewing and swallowing difficulties. Staff were to keep the resident upright while feeding and for 30 minutes after eating.

The Registered Dietitian (RD) confirmed the resident should have been positioned as close to 90 degrees as possible and the PSW should have been sitting on a stool while assisting with eating.

Failing to provide safe positioning for a resident while assisting with eating put the resident at risk for choking and aspirating.

Sources: Observations, a resident's plan of care and interviews with the RD and other staff. [501]

WRITTEN NOTIFICATION: Quality

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. i.

Continuous quality improvement initiative report

s. 168 (2) The report required under subsection (1) must contain the following information:

5. A written record of,

i. the date the survey required under section 43 of the Act was taken during the fiscal year,

The licensee has failed to ensure that the home's continuous quality improvement (CQI) initiative report contained the date that the Resident and Family/Caregiver Experience Survey was taken.

Rationale and Summary

The home's CQI initiative report did not contain the date the Resident and Family/Caregiver Experience Survey was taken. The Administrator confirmed that this date was not in the home's report.

Sources: Guildwood Quality Improvement Action Plan and an interview with the Administrator. [501]