Ontario

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

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Original Public Report

Report Issue Date: November 26, 2024.

Inspection Number: 2024-1054-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Guildwood, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22-25, 28-30, 2024, and November 6-8, and 12-13, 2024.
The inspection occurred offsite on the following date(s): October 31, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00128857-CI #2164-000027-24 was related to fall prevention and management.
- Intake #00127562-CI #2164-000023-24 was related to infection prevention and control.
- Intakes #00127772-CI #2164-000025-24 and #00127687-CI #2164-000024-24 were related to prevention of abuse and neglect.

The following CI intake(s) were completed:

- Intake #00124545-CI #2164-000021-24 was related to infection prevention and control.
- Intakes #00119227-CI #2164-000018-24 and #00128759-CI #2164-000026-24 were related to fall prevention and management.

The following Complaint Intake(s) were inspected:

- Intake #00128995 and #00124486 were related to housekeeping laundry and maintenance services, prevention of abuse and neglect and, resident care and services.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that the staff involved in the care of the resident collaborated with each other in the development of the plan of care related to fall prevention strategies.

Rational and Summary

On a specified date the resident had an unwitnessed fall while self-transferring from one surface to another and sustained an injury.

Personal Support Worker (PSW) stated that the resident had a history of self-transferring from one surface to another but failed to inform the registered staff prior to their fall with injury.

Fall Lead stated the PSW should have communicated their observations to the registered staff as a potential trigger to the resident falling, in order to prevent future falls.

Staff failed to communicate a potential fall trigger for the resident, which placed the resident at risk for fall with injury.

Sources: Fall committee minutes, interview with Fall Lead and PSW.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 failed to ensure that the care set out in the resident's plan of care was provided to them, as specified in their plan.

Rational and Summary

On a specified date, at a specified time, the resident had swelling to their hand, which was later diagnosed to be injured.

The resident had responsive behaviors during care and had a specified intervention.

While assisting the resident for bed, the PSWs stated the resident was exhibiting responsive behaviors during care. The PSW stated they did not implement the intervention as specified in the resident's care plan.

Staff failed to implement the resident's required intervention in response to their responsive behavior.

Sources: Interview with PSW and other relevant staff, the resident's clinical records.

WRITTEN NOTIFICATION: Accommodation services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (1) (a)
Accommodation services
s. 19 (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;

The licensee failed to ensure the organized program of housekeeping services for the home was complied with.

In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure all spa rooms are cleaned daily to maintain a safe environment for the residents, as required by the home's Spa Room Cleaning Procedure Policy #HL-05-01-12 A13. Specifically, the dusting and mopping of the entire floor was not completed.

Rationale and Summary

A complaint was lodged regarding the cleanliness of a specific resident spa room floor. A picture of the spa room floor taken on a specified date, showed the corner behind the spa room door was visibly soiled with dirt.

Support Services Manager (SSM) reviewed the picture and stated the floor appeared to have not been cleaned for many days.

Failure to comply with the daily cleaning of the specified spa room floor may impact the cleanliness of the home.

Sources: Policy #HL-05-01-12 A13 Spa Rooms Cleaning Procedures, dated March 2023, picture taken on a date specified, interview with SSM.

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with the falls prevention and management program strategies to reduce or mitigate falls for the resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to ensure

that the Fall Prevention and Management Program Policy #RC-15-01-01 was complied with. Specifically, staff did not complete the clinical monitoring record (CMR) as required.

Rationale and Summary

The resident had a unwitnessed fall on a specified date, at a specified time and was transferred to hospital at a specified time. As per the home's fall prevention and management policy, the CMR must be completed every hour for the first 4 hours. Upon review of the resident's clinical records it was identified that a second set of vitals for the CMR should have been completed at a specified time but it was not completed.

When the CMR was not completed for the first four hours after an unwitnessed fall, there was a risk that the resident was not monitored appropriately.

Sources: Interview with Fall Lead, resident clinical records, Policy #RC-15-01-01, Falls Prevention and Management Program, dated March 2023.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that the resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

Rationale and Summary

On a specified date at a specified time, the resident was noted to have a skin alteration. Register Practical Nurse (RPN) stated they did not complete the skin assessment as required when the resident had a new skin alteration.

Staff failed to complete a skin assessment for the resident at the time of identifying the skin alteration, which delayed the implementation of potential treatment.

Sources: Interview with RPN and resident clinical records.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the IPAC Lead failed to ensure that audits were conducted, at a

minimum quarterly, of specific activities performed by the program and recreation staff in the selection and donning and doffing of personal protective equipment (PPE), as required by Additional Requirement 2.1 under the IPAC Standard.

Rationale and Summary

The IPAC audits for the donning and doffing PPE section between specified dates, did not include program and recreation staff.

The Programs Manager (PM) and IPAC Lead (Clinical Coordinator) both acknowledged that the program and recreation staff were not audited on the donning and doffing of PPE.

Failure to conduct PPE audits on all staff may affect the effectiveness of the home's management of their IPAC program.

Sources: Review of Audit Summary Reports for a specified period in time (IC-PPE Donning Audit for additional precautions and IC-PPE Doffing Audit for additional precautions) and IPAC Standard for Long-Term Care Homes, Revised September 2023; and interview with IPAC Lead and other relevant staff.