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

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

Public Report

Report Issue Date: January 23, 2025

Inspection Number: 2025-1054-0001

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): January 16, 17, 20-23, 2025

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

- Intake #00132062 /2164-000031-24 related to resident to resident altercation.
- Intake #00131990 /2164-000030-24 related to resident to resident altercation.
- Intake #00133127 /2164-000034-24 related to a disease outbreak.
- Intake #00136213 /2164-000001-25 related to skin and wound prevention and management.

The following Complaint intake was inspected:

- Intake #00134974 related to fall.

The following Critical Incident intakes were completed:

- Intake #00131502 /2164-000029-24, #00132641 /2164-000033-24, and #00133483 /2164-000035-24 were related to falls.

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

Skin and Wound Prevention and Management

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
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 (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 a fall prevention intervention set out in a resident's plan of care was provided to the resident as specified in the plan. The resident had a fall that resulted an injury.

Sources: CI report, resident's clinical records, interview with staff.

WRITTEN NOTIFICATION: IPAC

NC #002 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 that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Additional Requirement 9.1 of the IPAC Standard for Long-Term Care Homes required Additional Precautions be followed in the IPAC program. Specifically, s. 9.1 (f) around the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal. Two staff were observed to present in the home's outbreak affected area with enhanced masking requirement without donning the required PPE.

Sources: Observation and interview with staff.

WRITTEN NOTIFICATION: IPAC

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
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 failed to ensure that resident symptoms were recorded on every shift. A resident was exhibiting symptoms of infection which were not consistently documented on each shift.

Source: Resident's clinical records and interview with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Conduct two random audits weekly, of the written plan of care for at minimum two residents for falls, to ensure clear directions are provided to staff regarding fall prevention interventions. These audits must be conducted for a minimum of four weeks upon service of this order.
2. Maintain a written record of audits conducted, including but not be limited to: date of audit, name and designation of auditor, resident name, audit findings and any corrective action taken in response to the audit.

Grounds
The licensee has failed to ensure that a resident's fall prevention interventions in their plan of care set out clear directions to staff and others who provided direct care to the resident.

The resident sustained a fall and required a transfer to the hospital. The resident was diagnosed with an injury that could not be treated with surgery. They passed away due to complications from the injury.

Failure to provide clear directions to the staff regarding a resident's fall prevention interventions put the resident at risk of falling and injury.

Sources: CI report, resident's clinical records, interview with staff.
This order must be complied with by March 7, 2025

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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
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:

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.