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
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Public Report

Report Issue Date: March 13, 2025
Inspection Number: 2025-1054-0002
Inspection Type: Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Guildwood, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 10, 11, 12, 13, 2025

The following intake was inspected:
- Intake: #00137923 related to Compliance Order #001 under Inspection #2025-1054-0001.

The following Critical Incident System (CIS) were inspected:
- Intake: #00136769/CIS #2164-000003-25 related to suspected abuse of a resident.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1054-0001 related to FLTCA, 2021, s. 6 (1) (c)

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #001 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 report was made to the Director immediately regarding an allegation of abuse of a resident.

A staff member reported suspected abuse of a resident to Director of Care (DOC) by staff. A CIS report was submitted to the Director the following day and the DOC acknowledged the incident should have been reported immediately.

Sources: CIS report and interview with DOC.

WRITTEN NOTIFICATION: Minimizing of Restraints

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

Non-compliance with: FLTCA, 2021, s. 34 (1) 1.
Protection from certain restraining
s. 34 (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.

The licensee has failed to ensure that a resident was not restrained or confined for the convenience of the staff.

A resident was found by staff, potentially restrained. A Registered Nurse (RN) confirmed that the resident was restrained to prevent the resident from standing up. DOC and RN acknowledged this was a restraint.

Sources: Interview with RN and DOC.