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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Public Report

Report Issue Date: June 6, 2025
Inspection Number: 2025-1054-0003
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): May 26-30, 2025 and June 2-6, 2025

The following intake(s) were inspected:

- Intake: #00142817/Critical Incident (CI) #2164-000007-25 – related to falls prevention and management
- Intake: #00143014 and intake: #00147163 – complaints related to allegations of neglect and resident care and services
- Intake: #00143173/CI #2164-000008-25, intake: #00144353/CI #2164-000013-25 and intake: #00148100/CI #2164-000019-25– related to disease outbreaks
- Intake: #00143505/CI #2164-000010-25 and intake: #00146274/CI #2164-000017-25 – related to prevention of abuse and neglect
- Intake: #00144945/CI #2164-000014-25 – related unknown cause of injury

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

Resident Care and Support Services
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to be treated with respect

NC #001 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. A staff member was moving a resident when the resident swung their arm toward the staff. The staff slapped the resident in response to this action.

Sources: A resident's clinical records, surveillance video and interview with staff.

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 has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan of care. The resident required an intervention to minimize injury from falls. The intervention was not provided to the resident when they sustained a fall.

Sources: A resident's clinical records, interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised, when the resident's care needs changed. The resident required a mobility aid with ambulation and the use of a device at all times when seated in wheelchair. The resident was observed seated in their wheelchair without the use of the device. The resident was also non-ambulatory and required assistance from staff. Staff indicated that the resident was no longer ambulatory and the device was not required when seated in wheelchair due to the risk for falls.

Sources: Observation, a resident's clinical records and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
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:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that Head Injury Routine (HIR) monitoring was initiated and completed for 72 hours after a resident's fall.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with. Specifically, registered nursing staff did not comply with the home's Neurological Signs/Head Injury Routine Policy to implement and complete HIR for 72 hours for an unwitnessed fall. The resident's assessment records revealed that HIR was not initiated immediately after the resident's unwitnessed fall. HIR monitoring was also not completed for two shifts during the 72 hour monitoring period.

Sources: A resident's clinical records, the home's Neurological Signs/Head Injury Routine Policy (RC-25-01-38, last reviewed: March 2025) and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
Required programs
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 a comprehensive pain assessment was completed for a resident when a new onset of pain was identified.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a pain management program to identify and manage pain in residents, and must be complied with. Specifically, registered nursing staff did not comply with the home's Pain Identification and Management Policy to complete a comprehensive pain assessment when the resident was experiencing pain.

Sources: A resident's clinical records, home's Pain Identification and Management Policy (RC-19-01-01, last reviewed March 2025) and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

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 that any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Additional requirement 5.6 of the IPAC Standard for Long-Term Care Homes required policies and procedures in place to determine the frequency of surface

cleaning and disinfection using a risk stratification approach and that surfaces are cleaned at the required frequency. The home's policy indicated high touch surface cleaning in isolation rooms or outbreak situations was required at a minimum of twice a day. On May 26, 2025, a housekeeping staff did not clean and disinfect high touch surfaces of two resident rooms on the outbreak unit during the morning shift.

Sources: Observation, home's High Touch Surface Cleaning and Disinfection policy (EVS2-P10.16, last reviewed date March 7, 2025) and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
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 ensure that the Director was immediately informed when two outbreaks of communicable disease were declared by the local Public Health unit.

Sources: CI reports and interview with the IPAC Manager.