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
Telephone: (866) 311-8002
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Modified Public Report (M)

Amended Report Issue Date: April 27, 2023	
Original Report Issue Date: April 25, 2023	
Inspection Number: 2023-1049-0002 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Scarborough, Scarborough	
Amended By Goldie Acai (741521)	**Director who Amended Digital Signature**

MODIFIED INSPECTION SUMMARY

This public inspection report has been revised to reflect Intake #00001327/CI: 2117-000015-22 and Intake #00005230/CI: 2117-000017-22 were removed from the summary of intakes. The Complaint, and Critical Incident System inspection, #2023_1049_0002 was completed on April 21, 2023.

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Lead Inspector Goldie Acai (741521)	**Additional Inspector(s)** Parimah Oormazdi (741672) Irish Abecia (000710) Dorothy Afriyie (000709)
Amended By Goldie Acai (741521)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred on the following date(s):
April 11-14, 17-21, 2023
April 12-14, 17-21, 2023

The following intake(s) were inspected:
Intake: #00001327/CI: 2117-000015-22, Intake: #00001743/CI: 2117-000011-22, Intake: #00002291/CI: 2117-000005-22, Intake: #00003338, Intake: #00005230/CI: 2117-000017-22, Intake: #00005586/CI: 2117-000018-22, Intake: #00006139, Intake: #00018727/CI2117-000002-23, and Intake: #00021935 were related to abuse.

Intake: #00006906/CI: 2117-000003-22, Intake: #00015371/CI2117-000025-22, Intake: #00017053/CI2117-000027-22 were related to falls; and
Intake: #00019589/CI2117-000003-23 was related to neglect.

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

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

AMENDED 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 (1) (c)

The licensee has failed to ensure that the resident's written plan of care set out clear directions to staff related to transfers.

Rationale and Summary:
A resident fell and sustained an injury. Their care plan indicated that they required the level of assistance for transfers. Their Kardex mentioned that they required a level of assistance for transfers but details about this transfer was not mentioned.

A Personal Support Worker (PSW) advised that the resident was transferred with the level of assistance from staff. Another PSW stated that the resident required a different level of assistance from staff. The Registered Practical Nurse (RPN) indicated that the resident should follow the transfer status mentioned by the second PSW and not the first.

The resident’s care plan and Kardex did not provide clear directions to staff related to their level of assistance for transfers.

Failure to set out clear directions for staff increased the resident’s risk for falls and injury.

Sources:
Resident's Progress Notes, Care Plan and Kardex; Interviews with PSW, RPN and PT.

[000710]

WRITTEN NOTIFICATION: PROTECTION FROM CERTAIN RESTRAINING

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

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

Rationale and summary:
A resident exhibited behaviours and was restrained by a PSW who then continued with their tasks. Later, an RPN discovered the resident was being restrained and released the resident.

The home's policy "Least Restraints, RC-22-01-01", last revised January 2022, defines physical restraint as "Any manual method, or any physical or mechanical device, material, or equipment, that is attached or adjacent to the person's body, that the person cannot remove easily, and that does, or had the potential to restrict the resident's freedom of movement or normal access to his/her body."

The PSW indicated that they had restrained the resident for a specific purpose. The Director of Care (DOC) and Associate Director of Care (ADOC), both acknowledged that the resident should have not been restrained for staff convenience.

Improper use of physical restraints increases the risk of injury to resident.

Sources:
Critical Incident (CI) report #2117-000003-23, investigation notes, home's policy "Least Restraints, RC-22-01-01", last revised January 2022, interview with PSW, RPN, DOC and ADOC.
[741672]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that a strategy was implemented for a resident in response to their behaviours.

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Rationale and summary:
The Behavioural Support Ontario (BSO) lead ordered an identified intervention for a resident who was exhibiting behaviours. However, this intervention was not implemented for a number of days, and as a result, the resident continued to exhibit behaviours.

The resident's clinical records indicated they had a history of behaviours. Therefore, the identified intervention was required for the resident's safety.

The BSO lead, and DOC, both acknowledged that the identified intervention was not provided to the resident within an appropriate time frame.

Failure to implement the intervention put the resident at increased risk for further injuries.

Sources:
Interview with BSO lead and DOC, and the resident's clinical records.
[741672]