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

Original Public Report

Report Issue Date: August 17, 2023	
Inspection Number: 2023-1054-0004	
Inspection Type: Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Guildwood, Scarborough	
Lead Inspector Ann McGregor (000704)	**Inspector Digital Signature**
Additional Inspector(s) Kehinde Sangill (741670)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, August 1-4 and 8-9, 2023

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

- Intake #00011931/CI#2164-000047-22 was related to staff to resident abuse.
- Intake #00083894/CI#2164-000008-23 was related to resident-to-resident abuse.
- Intake #00089435/CI#2164-000011-23 was related to falls prevention and management

The following Compliance Order was reviewed:

- Intake: #00087823 Follow-up - CO #001 / 2023-1054-0003.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2023-1054-0003 related to FLTCA, 2021, s. 24 (1) inspected by Kehinde Sangill (741670)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Responsive Behaviours
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 (10) (c)

The licensee has failed to ensure that the residents were reassessed and their plan of cares reviewed and revised when care set out in the plan had not been effective to protect one resident from another.

Rationale and Summary
A resident had responsive behaviour towards another resident. The resident was identified as being a trigger for the other resident's responsive behaviour when in their personal space. Both residents' care plans instructed staff to keep them apart and to redirect them when within each other's personal space.

Camera footage showed one resident sitting in the dining room at a table. That resident saw the other resident approaching their table and maneuvered to block the resident's path. As soon as the resident was within a touching distance, the resident sitting at the table, struck the other resident. Neither of the two staff in the immediate vicinity of the incident redirected the residents.

The Behavioural Support Ontario (BSO) lead indicated that the resident was at risk as long as they remain a trigger for the other resident. The BSO Lead also noted that interventions were sometimes ineffective because of staff's inability to anticipate every interaction between residents. The BSO lead acknowledged that neither resident was reassessed after the incident, and their care plans were not

reviewed and revised to prevent a recurrence.

The Director of Care (DOC) acknowledged that the interventions in place to protect the resident from another resident were not effective as staff were not following either residents' plan of care. The DOC also acknowledged that both residents should have been reassessed and their care plans reviewed and updated after the incident.

Failure to review and revise the plan of care for the residents increased the risk of further altercation and injuries between the residents.

Sources: Camera footage, residents' clinical records and interview with the DOC, BSO Lead and other staff.
[741670]

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)

The licensee has failed to ensure the care set out in the plan was provided to the residents as specified in the plan.

Rationale and Summary
i) The plan of care of one resident identified the other resident as a trigger for their responsive behaviour. The plan of care for the residents instructed staff to redirect them when in their personal space.

One resident approached another resident and both residents were observed to be one foot apart. They interacted for a few minutes and walked away on their own after the interaction. None of the staff in the immediate vicinity redirected the resident during this interaction.

A Registered Nurse (RN) stated that one resident should have been redirected when they stepped into the other resident's personal space.

The DOC acknowledged that the staff did not follow the resident's care plan when they did not immediately remove the resident from the other resident's personal space. The DOC indicated that the resident was at risk of getting hurt by the other resident when staff failed to redirect the resident.

Staff failure to follow the residents' care plans puts one resident at risk of injury.

Sources: Observations; residents' clinical records; and interview with RN, DOC and other staff.
[741670]

ii) A resident had responsive behaviours when their room was reorganized, and belongings were touched by staff. The plan of care instructed staff to complete required cleaning of the room when the resident was not present, and to be familiar with the identified triggers for the resident. The home's policy further instructed staff to be familiar with the plan of care, the specific interventions related to behaviour and be consistent in the application and implementation.

A Personal Support Worker (PSW) removed an item from the resident's room and did not replace it before the resident returned to the room. When the resident returned, the missing item triggered a responsive behaviour.

During an interview with the PSW, it was acknowledged that the resident's plan of care was not followed and resulted in responsive behaviours. Interview with the Registered Practical Nurse (RPN) verified that the PSW did not follow the plan of care for the resident. The DOC acknowledged that the PSW did not follow the plan of care for the resident and the home's responsive behaviour policy.

The removal of the item was an identified trigger for the resident which could have been avoided if the staff had replaced it before the resident returned to the room.

Source: The Resident's Plan of Care, interview with PSW, RPN, and DOC. Home's Responsive Behaviour Policy.
[000704]

WRITTEN NOTIFICATION: Specific Duties Re Cleanliness and Repair

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the home was kept clean and sanitary.

Rationale and Summary

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

It was observed that there were multiple smears of brown substances with foul odour on the floor of the visitor's washroom. Similar smears were observed on the floor in front of the reception desk and the vestibule leading into the main entrance.

A housekeeper identified the brown smears as fecal matter that were tracked through the home by a resident.

The Infection Prevention and Control (IPAC) lead stated that the presence of fecal matter on the floor was not sanitary and increased the risk of transmission of infection.

Failure to ensure sanitary conditions in the visitor's washroom increased the risk of spreading infection throughout the home.

Sources: Observations; Interviews with Housekeeper, IPAC Lead and other staff.
[741670]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulations 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A resident had a prior history of responsive behaviours towards residents and staff. Another resident had a history of wandering into other residents' personal space. This particular day, the one resident wandered into the other resident's personal space. The other resident pulled the resident close and struck them twice. The resident sustained an injury as a result of the interaction.

A RN acknowledged that they were the first to respond to the incident and witnessed the altercation.

A PSW, RPN (BSO Lead), RN and the DOC all acknowledged that physical abuse had occurred.

The home's policy on abuse and neglect indicated that the home had a zero tolerance of abuse, and abuse of a resident would not be tolerated under any circumstance.

The home failed to protect the resident from abuse by another resident.

Sources: CIS, residents' clinical records, home's investigation notes, Home's Policy on Zero Tolerance of Resident Abuse and Neglect; interviews with the PSW, RPN (BSO Lead), RN, DOC and other staff. [741670]

WRITTEN NOTIFICATION: Resident Records

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (a)

The licensee has failed to ensure that a written record was maintained for the resident.

Rationale and Summary
A resident had a history of responsive behaviour towards staff and residents. There was an expression of responsive behaviour by the resident that resulted in injury to another resident.

The home's responsive behaviour policy directed care staff to document on each shift the behaviour of all residents who displayed responsive behaviour with appropriate tools including the Dementia Observation System (DOS) tool.

Progress note indicated that DOS monitoring was completed, to monitor the resident's responsive behaviour. Staff were unable to produce the completed DOS monitoring tool for the resident upon request.

The BSO Lead stated that they could not find the DOS monitoring tool that was completed for the resident during the period.

The BSO Lead and the DOC verified that the resident's DOS monitoring tool was part of the resident's records. The DOC stated that the resident's DOS monitoring tool should have been maintained.

Failure to maintain the resident's DOS monitoring records could impact the ability to accurately identify patterns in responsive behaviour and recognize new triggers.

Sources: Review of resident's clinical records, home's policy on Responsive Behaviours; and interview with the DOC, BSO Lead and other staff.
[741670]