

**Ministry of Health
and Long-Term Care**

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
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**Ministère de la Santé
et des Soins de longue durée**

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
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January 12, 2011

Mr. Andre Barros
Administrator
Extendicare Guildwood
60 Guildwood Parkway
Scarborough ON M1E 1N9

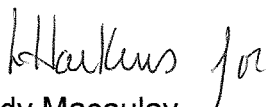
Dear Mr. Barros:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on October 14 and 15, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely


Judy Macaulay
LTC Home Inspector – Nurse

c President, Resident's Council
President, Family Council



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection October 14, 15, 2010	Inspection No/ d'inspection 2010_104_2164_14Oct111136	Type of Inspection/Genre d'inspection Critical Incident: O-000481
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Licensee/Titulaire

Extendicare Toronto Inc. [a subsidiary of Extendicare (Canada) Inc]
3000 Steeles Avenue East, Suite 700, Markham, ON, L3R 9W2
Fax: 905-470-5588

Long-Term Care Home/Foyer de soins de longue durée

Extendicare Guildwood
60 Guildwood Parkway, Scarborough, ON, M1E 1N9
Fax: 416-269-5123

Name of Inspector(s)/Nom de l'inspecteur(s)

Judy Macaulay, # 104

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an inspection related to critical incident 2164-000022 involving an incident of physical aggression.

During the course of the inspection, the inspector spoke with the Administrator, the Director of Care, several registered nursing and PSW staff, a housekeeping staff, and the residents involved.

During the course of the inspection, the inspector reviewed the identified residents' charts and observed the residents involved and their rooms.

The following Inspection Protocol was used during this inspection:
Responsive Behaviours

☐ There are no findings of Non-Compliance as a result of this inspection.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. An identified resident took an object and used it to hit another resident.
2. The care plan noted the identified resident's behavioural triggers and history of aggression.
3. Interventions to address these behaviours included removing this specific object.
4. During this inspection the specific object was noted to be in the hallway wall adjacent to this resident's room.
5. The care set out in the plan of care was not provided to this resident as specified in the plan of care as the staff failed to remove the specific object out of the resident's area.

Inspector ID #: 104

Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

**Signature of Health System Accountability and Performance Division
 representative/Signature du (de la) représentant(e) de la Division de la
 responsabilisation et de la performance du système de santé.**

Title:

Date:

Date of Report:

J. Macaulay, LTCH inspector - nursing
Dec. 23, 2010