Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 29, 2016	2015_393606_0017	030231-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BAYVIEW
550 CUMMER AVENUE NORTH YORK ON M2K 2M2

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

JANET GROUX (606), MATTHEW CHIU (565), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 10, 12, 13, 16, 17, 19, and 20, 2015.

During the course of this inspection one critical incident intake was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Dietitian, Housekeeping, Dietary Aide (DA), Social Worker (SW), Program Manager (PM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Office Manager (OM), Residents, and Substitute Decision Makers (SDM).

During the course of the inspection the inspector(s) conducted observations of medication administration, meal service delivery, resident home areas, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, relevant policies and procedures and Residents' and Family Council meetings minutes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to shall ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly cared for in a manner consistent with his or her needs.

A review of a critical incident report on an identified date indicated that an identified resident's SDM notified the home on an identified date that he/she witnessed an identified PSW interaction with the resident to be inappropriate, lacked understanding and insight into dealing with the resident's identified condition and thereby causing a change in the resident's behaviour.

A review of the identified resident's plan of care indicated resident requires extensive assistance by one staff with all hygiene needs related to the resident's identified limitations. Staff were directed to allow the resident to verbalize any of his/her needs, inform him/her of what to expect during care, get permission to start care, and do not rush him/her.

Interview with the SDM revealed that on an identified date, while he/she was assisting an identified PSW to give care to the resident, he/she witnessed the resident becoming resistive to care and getting agitated. He/she informed the identified PSW to discontinue giving the resident care due to the resident's increasing agitation. However, the identified PSW ignored the request and continued to proceed in giving care to the resident causing the resident's agitation to escalate. The care was discontinued only when an identified RN was called in to assist.

Interview with the identified RN revealed staff are to provide the resident information about the care to be provided and obtain permission prior to starting and stated the identified PSW was aware of this but did not follow.

Interview with the identified PSW revealed that he/she provided care according to the resident's plan of care care.

Interview with the DOC confirmed the staff member did not respect the resident's right to be properly cared for in a manner consistent with the identified resident's needs as mentioned above. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. s. 6. (1) The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A review of a critical incident report dated on an identified date, indicated that an identified resident's SDM notified the home that on an identified date, he/she witnessed a PSW interaction with the resident to be inappropriate, lacked understanding and insight into dealing with the resident's identified condition and thereby causing the resident's behaviours to escalate.

Review of the identified resident's plan of care indicated that the following revisions were made to the
resident's plan of care as a result of the above identified incident, but were not added

until four months later.
-If resident refused shower, offer a bed bath.
-If resident's behavior begin to escalate during a shower - stop the task as soon as reasonably possible.

Interview with the DOC revealed that during the home's investigation and interviews with staff, the above strategies were discussed to add to the resident's plan of care and confirmed that the plan of care should have been revised and updated. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident's vision.

A review of an identified resident's identified assessment on an identified date, revealed the resident had identified cognitive and visual impairments. A review of the resident's plan of care indicated the resident's visual impairment contributed to the resident's high risk for fall. There was no plan of care for the resident based on the resident's vision.

Interviews with an identified PSW, RN, and ADOC confirmed the resident was visually impaired and he/she could identify objects. The identified RN and ADOC confirmed the resident's plan of care did not include a vision focus detailing the planned care for the resident. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of an identified resident's plan of care with an identified start date, identified resident with altered skin integrity to identified areas of his/her body. An intervention in the plan of care indicated the PT to assess a part of the resident's personal aid equipment.

Further review of the resident's clinical records revealed no documentation of a physiotherapy assessment regarding the part of the resident's personal aid equipment.

Interview with an identified RPN revealed that the home's practice is all assessment would be documented in the resident's chart and confirmed that he/she could not find a physiotherapy assessment regarding the personal aid equipment.

Interview with the PT revealed that he/she did not receive a referral and therefore did not

complete an assessment as mentioned above. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The home uses a PointClickCare (PCC) assessment instrument that is specifically designed for assessment of bladder incontinence. A review of an identified resident's RAI-MDS assessment dated on three identified dates, revealed the resident was frequently incontinent of bladder. A review of the resident’s clinical assessment record revealed the resident had not received an assessment of incontinence since he/she was admitted to the home on an identified date.

Interviews with an identified PSW and RN confirmed the resident had bladder incontinence. The registered staff confirmed the home uses the PCC assessment instrument for assessment of bladder incontinence upon admission and when a change in the resident’s continence status had occurred. The staff member confirmed that the identified resident did not receive the assessment of incontinence that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to provide training related to continence care and bowel management to all staff who provided direct care to residents on an annual basis.

A review of staff training records revealed and interview with the ADOC confirmed forty one per cent of staff who provided direct care to residents did not receive training related to continence care and bowel management in 2014 as required. [s. 221. (1) 3.]

Issued on this 21st day of February, 2016

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.