Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 25, 2017	2016_518645_0010	034046-16	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

DEREGE GEDA (645), NITAL SHETH (500)

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): Decmber 8, 9,12, 13, 14, 15, 16, 19, 20, 21, 22, 2016.

The following intakes were inspected concurrently during this RQI:
Critical Incident (CI) Intakes related to transferring and positioning# 003087-16, and fall prevention #007497-14.

During the course of the inspection, the inspector(s) spoke with 'Administrator, DOC, Program Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Wound Nurse(ET), Personal Support Workers (PSWs), Presidents of Residents' and Family Council, Residents and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection prevention and control practices, reviewed clinical health records, reviewed Residents' Council miniutes, staffing schedules/assignments, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of Critical Incident revealed that resident #007 had an incident in 2016 that caused an injury that resulted in a significant change in the resident's health status. PSWs #104 and #105 reported that the resident had a fall during a transfer. The resident sustained impaired skin integrity on an identified part of the body. The resident returned from the hospital with treatment with in two days.

A review of the resident's written plan of care revealed that the resident required an identified type of device for all transfers due to various health conditions. Two staff are required to assist the resident with a transfer, one staff to operate the device and other to ensure the resident's safety.

Interviews with PSWs #104 and #105 revealed that the resident was transferred using a device. All of the sudden, the resident fell and landed on his/her side and sustained an injury. The PSWs reported to a nurse and the resident was sent to the hospital for treatment. As per both PSWs it was a shock for them that the resident all of sudden landed on the floor during a transfer.

A review of the home's policy #01-03, entitled "Safe Lifting with Care Program", revised May 2009, indicated that two staff to apply and use the device, resident must be centered on the device, staff to ensure the device is applied and used correctly. Both staff must be ready and positioned correctly to complete the transfer.

A review of the home's investigation record and interview with DOC revealed that both PSWs received discipline for the unsafe transfer and the device was not applied safely. As a result the resident was able to fall and strike the floor and sustained an injury requiring treatment. DOC also indicated that one person should be with the resident and other staff should operate the device, which was not the case in the above mentioned incident. During the investigation, home identified that both staff members were involved in one task and it was not a safe transfer. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Residents' Council had advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee provided a written response within 10 days of receiving the advice.

Interview with members of the Residents' Council revealed ongoing dietary and laundry related concerns were raised in 2016 meetings by residents and the home did not provide written responses to the Residents' Council within 10 days. Residents' raised multiple concerns such as table rotation was not always followed during meal services, the menu was not easy to read for residents and concerns about missing clothing.

A review of the home's Residents' Council meeting minute in 2016 revealed the three above mentioned concerns were raised at the meeting.

A review of an email trail for responses forwarded by manager #114 to the president of the Residents' Council revealed that responses were not provided to the president of the Residents' Council within 10 days of receiving concerns. Concerns for table rotation and daily menu posting were raised during Residents' Council meeting in 2016. The president of the Residents' Council received responses via email later 2016 after the 10 days have passed for both dietary and missing clothing concerns.

Interview with Manager #114 revealed that he/she prepares minutes for Residents' Council, and forwards concerns which arose during the meeting to respective managers by email. Once he/she receive response from the manager of the respective department, he/she would forward that email to the president of the Residents' Council. Manager #114 confirmed that it was over 10 days by the time the president of the Residents' Council received the email responses for concerns raised during the meeting. [s. 57. (2)]

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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

Issued on this 26th day of January, 2017

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

Original report signed by the inspector.