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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2017	2017_646618_0023	025188-17	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

CECILIA FULTON (618), NICOLE RANGER (189)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 6, 7, 8, 9, 10, 14 and 15, 2017.

A Critical Incident related to plan of care, was also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Physiotherapist (PT), Social Worker (SW), Environmental Services Manager (ESM), Housekeepers (HSK), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control practices, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 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. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

In June 2017, the home submitted a Critical Incident System Report (CIR) reporting an incident that caused an injury to resident #010. The CIR report stated that on an identified date in June 2017, resident #010 reported to the Registered Nurse (RN), that they were experiencing pain in an identified body area.

X-rays taken in June 2017, did not reveal any injury, however the resident continued to report tenderness in the area and staff noted bruising on the identified body part. A second x-ray was completed three days later, which showed a suspected identified injury. A subsequent report provided by the hospital confirmed the injury to the identified body part.

A review of resident #010's written plan of care dated March 2017, revealed that two staff are required to provide the identified care needs.

An incident involving resident #010 occurred in June 2017 when PSW #103 entered resident #010's room and found the resident to be restless and attempting to climb out of bed. PSW #103 revealed that he/she transferred the resident from bed to chair by him/herself. PSW #103 revealed to the inspector that he/she was aware that resident #010 required two persons to assist with transferring.

Interview with the DOC confirmed that PSW #103 did not follow the plan of care related to resident #010 transfers. [s. 6. (7)]

2. The licensee has failed to ensure that the following was documented: the provision of the care set out in the plan of care.

In June 2017, the home submitted a Critical Incident System Report (CIR), reporting an incident that caused an injury to resident #010. The CIR report stated that in June 2017, resident #010 reported to the Registered Nurse (RN), that they were experiencing pain in an identified body area.

X-rays taken in June 2017, did not reveal any injury, however the resident continued to report tenderness and was exhibiting bruising on the identified body area. A second x-ray was completed three days later, showed a suspected identified injury. A subsequent report provided by the hospital confirmed the injury to the identified body area.

Interview with RPN #111 revealed that in May 2017, he/she was informed by PSW #104 that resident #010 was sitting on the floor. RPN #111 reported that when he/she entered the room he/she found resident #010 sitting on the floor. RPN #111 stated that PSW #102 then entered into the room and informed RPN #111 that the resident had not fallen, but that PSW #102 had assisted the resident into this position on the floor when he/she discovered the resident about to slip off the edge of the bed. RPN #111 reported that he/she assessed the resident and that he/she and PSW #102 transferred the resident back into the bed.

The inspector reviewed the progress notes for the identified date in 2017, which revealed that there was no documentation of this incident in the resident's progress notes. Interview with RPN #111 confirmed that he/she had not documented the incident or initiated a follow up investigation.

Interview with the DOC confirmed that RPN #111 had not documented the incident that occurred on the identified date in 2017, as required. [s. 6. (9)]

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 residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff.

This inspection was initiated when the inspection's initial tour, on November 6, 2017, at 1000hrs, revealed several doors that were not locked as required.

The doors that were identified as not being locked were:
1. The door to the soiled utility room on the east side behind the nursing station.
2. A fire door which exits to a court yard, across the hall from the ADOC's office. When opened this door alarmed, however it was identified by the Environmental Services Manager (ESM), that this door should have been locked and not able to be opened.
3. A door located in the small cafe dining area on the east side which exits into the court yard.
4. The West side SPA room door (across from room 123).
5. Glass double doors - going to the courtyard were not closed properly and were able to be easily pushed open leaving a gap of about 6 inches - it would have posed a definite injury risk to residents.

The ESM confirmed that these doors were not locked as required. [s. 9. (1) 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 all doors leading to non-residential areas were kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

A review of the home's policy "Falls Preventions and Management Program – Post fall Management ", RC-15-01-01, February 2017, indicates that as part of the post fall follow up staff are to refer to the Restorative Care, PT/OT, Dietitian, Housekeeping, Maintenance and other members of the interdisciplinary team for follow up as appropriate.

During stage one of the RQI, resident #003 triggered for a fall which occurred within the last 30 days. Record review revealed that at an identified time in October 2017, resident #003 was found in the washroom without his/her walker. Resident was assisted back to bed using his/her walker, but later reported that he/she had soreness in an identified body part. The next day, resident #003 reported that he/she had fallen in the washroom on the above identified occasion. Upon receiving this information from the resident, the staff initiated a post falls assessment.

Interview with RN #100 revealed post fall assessments are to be conducted for any fall that is identified and that part of the post fall protocol is a referral to the Physiotherapist (PT). Review of resident #003's post fall assessment revealed that no referral had been made to the PT. Interviews with RN #100 and PT #113 confirmed that a post fall physio assessment had not been completed for resident #003 following the above mentioned fall as required. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

This inspection was initiated as a result of observations made by the Inspector when observing a medication administration pass in November 2017. During this observation, the inspector observed five resident's Individual Monitored Narcotic Medication Record which had not been properly completed and signed for. The forms failed to document the quantity of the medications initially received from the pharmacy and the quantity of the medications remaining.

Inspection of the emergency drug box revealed 10 additional individual narcotic records that had also not been properly completed to indicate the quantity of medication initially received from the pharmacy and the quantity of the medication remaining. RPN #115 was the registered staff in attendance during this observation and he/she confirmed the inspectors observations of the forms.

O. Reg 70/10 r. 114(2) – The licensee shall ensure that written polices and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the homes' policy 6-3 "Receiving Monitored Medications", dated February 2017, indicated that all monitored medications received into the home are checked for accuracy in the quantity and their receipt record. The registered staff are to confirm quantity received and record the quantity in all required areas including paper or electronic, and all pharmacy required delivery manifests.

Interview and observation of the monitored narcotic medication record by the DOC , confirmed that forms had not been completed as required by the registered staff receiving the medications from pharmacy to ensure the accurate acquisition, receipt, storage and administration of all drugs used in the home. [s. 8. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures were developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On November 6, 2017, during stage one of the RQI, the inspector observed resident #007's and resident #008's wheelchair to be visibly soiled. Inspector observation of resident's #007 and #008's wheelchairs on November 7 and November 8, 2017, revealed them to be in the same, soiled condition.

On November 7, 2017, the inspector observed resident #009's wheelchair to be visibly soiled. Inspector observation of resident #009's wheelchair on November 8, 2017, revealed it to be in the same, soiled condition.

The inspector reviewed the wheelchair cleaning schedule for the residents. The wheelchair for resident #007 was scheduled to be cleaned every Friday. The wheelchair cleaning schedule had not been signed by the staff as completed on identified dates in October and November 2017. The wheelchair for resident #008 was scheduled to be cleaned every Monday. The wheelchair cleaning schedule had not been signed by staff as completed in October 2017. The wheelchair for resident #009 was scheduled to be cleaned every Monday. The wheelchair cleaning scheduled was marked as "resident refused" for the entire month of October, and had not been signed off for and identified date in November 2017.

Interview with RN #100 revealed that the wheelchairs are cleaned by the night staff as per schedule and documented in the wheelchair cleaning schedule binder which is located in the nursing station. The inspector and RN #100 observed resident #007 and resident #008 wheelchairs in November 2017, and RN #100 confirmed that the wheelchairs were visibly soiled and did not appear to be cleaned by staff.

Interview with resident #009 in November 2017, confirmed that his/her wheelchair had not been cleaned for the month of October 2017, and that his/her wheelchair was recently cleaned on an identified date in November 2017 by the night staff. [s. 87. (2) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

During observations of the south unit medication cart on November 15, 2017, the inspector noted non drug and non drug-related items being stored in the medication cart. This item identified as a bottle of alcohol which had not been prescribed for use to any resident.

Interview with the DOC and RN #105 confirmed that this item should not be in the medication cart. [s. 129. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is: (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During the record review of the homes' Medication Incident Summary for the period of January 1 to March 31, 2017, the inspector reviewed three medication incidents.

The incident reports for residents #012 and #013 revealed that both residents had been administered identified prescribed medications which were past their discard date. Review of both of these medication incidents revealed that neither resident's Substitute Decision Makers (SDM), or the resident's attending physician had been notified of the incidents. The medication incident for resident #012 also did not include a record of immediate actions taken to assess and maintain the resident's health.

Interview with the Director of Care (DOC) confirmed that the SDMs and attending physicians were not notified of the residents' medication incidents. [s. 135. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy include that any controlled substance that are to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substances that are available for administration to a resident, until the destruction and disposal occurs.

The home's narcotic drug destruction process directs the registered staff that all controlled substances which are to be destroyed are to be stored in a designated area separate from any controlled substances that are available for administration to a resident and maintained under double lock until the destruction and disposal occurs.

On November 15, 2017, during the medication administration pass with RPN #115, the inspector observed a discontinued narcotic card with 13 tablets of the identified medication in the package for resident #014 in the double locked narcotic box inside an identified unit medication cart. Review of the physician's order revealed that this identified medication had been discontinued on an earlier identified date in November 2017. This discontinued medication had not been removed for storage to a separate area designated for drugs which are to be destroyed, but remained in the narcotic bin of the medication cart.

Interviews with the DOC confirmed that the expired medications had not been removed and stored in a double locked storage area, separate from any controlled substances that are available for administration to a resident, until the destruction and disposal occurs as per process. The home's expectation is the discontinued narcotic medication be stored in the double locked box in medication room on the south unit. [s. 136. (2) 1.]

WN #8: 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:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training required under for the purpose of 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: Fall prevention and management.

Record review of the home's staff training records, and interview with the DOC confirmed that 20 out of 136 direct care staff had not received training in falls prevention and management in 2016. [s. 221. (1) 1.]

Issued on this 29th day of November, 2017

[redacted]

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

Original report signed by the inspector.