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 |
|---|---|---|---|
| Sep 13, 2018 | 2018_626501_0014 | 020200-18 | Resident Quality Inspection |

## Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

## 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

SUSAN SEMEREDY (501), JOANNE ZAHUR (589), JULIEANN HING (649)

## 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): August 9, 10, 13, 14, 15, 17, 21, 22, 23, and 24, 2018. Additionally an off-site interview was conducted August 27, 2018.**

**During the course of this inspection the following intakes were inspected:**
**#025256-17 (CIS #2460-000015-17) related to a fracture;**
**#027775-17 (CIS #2460-000017-17) related to a fall resulting in a fracture;**
**#004750-18 (CIS #2460-000003-18) related to a fracture and subsequent death; and**
**#008761-18 (CIS #2460-000006-18) related to infection prevention and control.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RD), Food Service Supervisor (FSS), Personal Support Workers (PSWs), Family and Residents' Council Presidents, residents, family members and substitute decision-makers.**

**During the course of the inspection, the inspectors observed staff and resident interactions, the provision of care and staff adherence to infection prevention and control practices and reviewed health records, program evaluations, infection prevention and control surveillance logs, investigation notes and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Reporting and Complaints**
**Residents' Council**
**Skin and Wound Care**

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

**6 WN(s)**
**5 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #002 triggered from stage one of the Resident Quality Inspection (RQI) for low body mass index (BMI) with no plan. Review of resident #002's most recent written plan of care indicated that the resident was to be provided with an identified diet texture.

Observation of resident #002 during an identified meal, indicated that the resident was served a different diet texture. During an interview with dietary aide #112, they showed the inspector the diet list which indicated that resident #002 was to receive this texture.

During an interview with PSW #101, they stated that they thought resident #002's diet texture changed a few months ago. During an interview with Registered Dietitian (RD) #104, they stated that this diet texture discrepancy was brought to their attention the day before and they immediately re-assessed the resident and changed the diet texture in the resident's plan of care. The RD could not explain why there had been a discrepancy but acknowledged that this could have posed a risk to the resident.

During an interview with the Food Service Supervisor (FSS) #115, they stated they always cross-check the diet orders on the diet list with the written plan of care and thought that a diet change had occurred sometime after the last quarterly assessment.

The RD told the inspector that the Dietary Department has since reviewed their processes for changing diet orders.

The RD confirmed resident #002's written plan of care did not provide clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. 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.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC). The CIS report indicated that resident #011 was sent to the hospital on an identified date for assessment of altered skin integrity. Review of progress notes indicated the home received information later in the day that there was a change in health condition.

According to a Minimal Data Set (MDS) assessment, resident #011 was totally dependent for bed mobility and bathing and required two or more persons to physically provide assistance. The mode of transfer was an identified assistive device. Review of the written plan of care for resident #011 stated that two staff are needed for all aspects of positioning, re-positioning, turning and bathing.

Review of a written statement from PSW #123 indicated that on an identified date, PSW #123 turned resident #011 to put an identified assistive device under the resident in bed and saw altered skin integrity on an identified body part. The PSW reported this immediately to RPN #131 who told the PSW to report to RN #125. According to the PSW’s statement, RN #125 told the PSW it was old altered skin integrity. PSW #123 then called for another PSW to help transfer resident #011 and as soon as the shower was finished, PSW #123 called for help to transfer the resident back to bed.

During an interview with PSW #123, they told the inspector that they had moved resident #011 to prepare to put the identified assistive device on without another PSW present. As well, PSW #123 stated that PSW #124 helped transfer resident #011 but PSW #123 admitted that PSW #124 did not stay in the shower room for the whole time. During an interview with PSW #124, they stated that they recalled not staying in the shower room but regularly returned to check on them.

Review of a discipline letter to PSW #123 indicated the care provided to resident #011 was in “violation of the care plan” as the PSW had turned, repositioned and showered

resident #011 without a second staff member.

During an interview with DOC #118, they confirmed that PSW #113 failed to provide the care set out in the plan of care to the resident as specified in the plan. [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 written plan of care sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and resident's responses to interventions were documented.

The home submitted a CIS report to the MOHLTC that indicated resident #011 was sent to the hospital on an identified date for assessment of altered skin integrity. Review of progress notes indicated the home received information later in the day that there was a change in health condition.

Review of a written statement from PSW #123 indicated PSW #123 turned resident #011 to put an identified assistive device under the resident and saw altered skin integrity on an identified body part. The PSW reported this to RN #125. According to the PSW's statement, RN #125 told the PSW it looked like old altered skin integrity and returned later stating that the altered skin integrity was already documented.

During an interview with RN #125, they stated that after seeing the altered skin integrity on resident #011, they checked the progress notes and found a note that indicated there was altered skin integrity on an identified body part. Review of this progress note, stated that there was altered skin integrity that still persists but was improving. Review of the wound assessment of the same date indicated that the altered skin integrity was on a different body area. Review of a progress note of another date indicated there was altered skin integrity on a different body area. During a subsequent interview with RN #125, they stated they had not checked these other assessments and thought the altered skin integrity that PSW #123 pointed out to them was the same of what had already been documented.

The inspector reviewed assessments and progress notes for resident #011, and found that RN #125 did not document the assessment they completed that indicated that altered skin integrity was brought to their attention and was assessed to be an old altered skin integrity. During the interview with RN #125, they admitted they failed to document the incident of the altered skin integrity being brought to their attention.

During an interview with DOC #118, they confirmed that RN #125 should have documented either a progress note or a skin assessment for the above mentioned altered skin integrity. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The home submitted a CIS report to the MOHLTC that indicated resident #011 was sent to the hospital on an identified date for assessment of altered skin integrity. Review of progress notes indicated the home received information later in the day that there was a

change in health condition.

Review of a written statement from PSW #123 indicated PSW #123 turned resident #011 to put an identified assistive device under the resident and saw altered skin integrity on an identified body part. The PSW reported this to RN #125. According to the PSW's statement, RN #125 told the PSW it looked like old altered skin integrity and returned later stating that the altered skin integrity was already documented.

During an interview with RN #125, they stated that after seeing the altered skin integrity on resident #011, they checked the progress notes and found a note that indicated there was altered skin integrity on an identified body part. Review of this progress note, stated that there was altered skin integrity that still persists but was improving. Review of the wound assessment of the same date indicated that the altered skin integrity was on a different body area. Review of a progress note of another date indicated there was altered skin integrity on a different body area. During a subsequent interview with RN #125, they stated they had not checked these other assessments and thought the altered skin integrity that PSW #123 pointed out to them was the same of what had already been documented.

The inspector reviewed assessments and progress notes for resident #011 for an identified time period, and found that there was no weekly assessment of the altered skin integrity. Although RPN #131 completed weekly wound assessments for two other areas of altered skin integrity for resident #011 on an identified date, they did not complete an assessment for the above mentioned altered skin integrity.

During an interview with RPN #131, they remembered doing weekly wound assessments for resident #011 on an identified date. RPN #131 stated that weekly wound assessments for other identified areas of altered skin integrity were performed by the evening registered staff.

During an interview with DOC #118, they confirmed that a weekly wound assessment was not completed for the above mentioned altered skin integrity. The DOC stated that registered staff are expected to conduct weekly assessments for residents with altered skin integrity and in this case the registered staff failed to do so. [s. 50. (2) (b) (iv)]

***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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The home submitted a CIS report to the MOHLTC that indicated resident #011 was sent to the hospital on an identified date for assessment of altered skin integrity.

Review of resident #011's progress notes indicated the resident was sent to the hospital on an identified date. A further progress note, for the same day, indicated that the resident had a change in health condition.

Review of a calendar indicated the home submitted the CIS report three business days after the occurrence of the above incident.

During an interview with DOC #118, they confirmed that they failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital. [s. 107. (3) 4.]

2. The home submitted CIS report to the MOHLTC on an identified date. The CIS report indicated that resident #010 was sent to the hospital on an identified date, for assessment and the home received information later in the day that the resident had a significant change in health condition.The home received information on an identified date that the resident passed away and upon investigation with the hospital, found that the resident expired on an identified date.

Progress notes for resident #010 indicated the resident was sent to the hospital on an identified date. A further progress note revealed the resident was admitted to the hospital. The following day a progress note stated resident #010 had an identified medical intervention.

During an interview with DOC #118, they could not explain why they did not report the above incident within one business day. [s. 107. (3) 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 inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The medication inspection protocol (IP) was completed as a mandatory task during the RQI. A review of medication incidents and/or errors for the last two quarters was completed as part of the IP. This review indicated that a medication error had occurred involving resident #020. A further review indicated resident #020 had been exhibiting a responsive behaviour on an identified date, and RPN #116 had administered a medication ordered for a different time of the day in an attempt to manage the responsive behaviour.

A review of resident #020's electronic medication administration record (e-MAR) and the physician orders indicated the above mentioned identified medication was prescribed to be given at an identified time and another identified medication had been ordered to be given as needed (PRN).

During an interview, RPN #116 indicated they had administered the identified medication at an identified time, instead of administering the PRN medication. RPN #116 further indicated they had not completed the required medication administration rights prior to administering the above mentioned medication to resident #020 and as a result administered the incorrect medication. RPN #116 agreed that they had not administered medication to resident #020 according to the prescriber's direction.

During an interview, ADOC #114 verified RPN #116 had failed to ensure that drugs were administered to resident #020 in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact**

**Specifically failed to comply with the following:**

**s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that contact was maintained with the resident who is on a medical absence or with the health care provider, to determine the return date to the home.

The home submitted a CIS report to the MOHLTC that indicated resident #010 was sent to the hospital on an identified date for assessment and the home received information later in the day that the resident was diagnosed with a change in health condition. The home received information on an identified date, that the resident passed away and upon investigation with the hospital, the home found that the resident expired on an identified date.

Review of progress notes for resident #010 indicated that the home did not attempt to contact the hospital on identified dates.

During an interview with DOC #118, they confirmed that the home had not maintained contact with the service provider to determine when resident #010 would be returning to the home. [s. 141. (1)]

**Issued on this 4th day of October, 2018**

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

**Original report signed by the inspector.**