Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 16, 2020	2020_714673_0007	000668-20, 002482-20, 017574-20, 020261-20, 020788-20, 022365-20, 022499-20	Critical Incident System

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

BABITHA SHANMUGANANDAPALA (673), HARSIMRAN KAUR (654)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 9,10, 12,13, 16-20, and 23-27, 2020, and offsite December 1, 2020

The following intakes were inspected:
-log #020788-20, CI 2460-000014-20, related to unexpected death of a resident
-log #002482-20, CI 2460-000005-20, related to missing controlled medications
-log #000668-20, CI 2460-000001-20; and log #017574-20, CI 2460-000011-20, related to injury of unknown cause with significant change in resident's condition
-log #022499-20, CI 2460-000015-20; log #022365-20, CI 2460-000016-20; and log #020261-20, CI 2460-000013-20 related to fall with injury.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Director of Care (DOC), Administrator, Programs and Activities Manager, Physiotherapist, Activation Aides, residents, family members, and physicians.

During the course of the inspection, the inspectors observed care provided to residents, and reviewed the home's and residents' records.

This inspection was completed concurrently with inspection # 2020_714673_0006.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Personal Support Services
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care related to a diagnostic test order for a resident.

Resident #008 had a fall and was transferred to the hospital the next day then readmitted to the home with no injuries. Three days after their return from the hospital, the resident refused to have an diagnostic test which had been ordered by the home's physician. The resident continued to express pain and was unable to bear weight for the next 20 days. The diagnostic test was taken 21 days after their initial refusal, and the results indicated an injury.

RN #112 indicated that the registered staff were required to re-fax the diagnostic test requisition to the lab after the resident first refused it. The diagnostic test requisition was not re-faxed to the lab for more than two weeks. The RN and the Administrator of the

home acknowledged that staff did not collaborate with each other in the implementation of an order for a diagnostic test.

Sources: A review of the resident's clinical file, progress notes, CI report, and staff interviews. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the implementation of the plan of care related to an order for an assistive aide for resident #023.

The resident's orders included that registered staff were to ensure that the resident was using the assistive aide for locomotion while going for a treatment three days per week. The order stated not to use a different specified assistive aide.

The resident's assistive aide went missing during a treatment visit. In the 60-day period following this, it was documented on 11 occasions by staff that the resident' assistive aide was missing. During the time the aide was missing, the resident used the assistive aide staff were directed not to use while going for treatment.

The process in the home to address a missing assistive aide was for the registered staff to inform the substitute decision maker (SDM) and make a referral to the physiotherapist to find a replacement. There was no documentation that the SDM was notified. A referral to the physiotherapist was made 56 days after the aide was first noted to be missing, after which time the resident's assistive aide was replaced.

Sources: Progress notes, EMAR, Physiotherapist referral, RPN #126, RN #116 [s. 6. (4) (b)]

3. The licensee has failed to ensure documentation of the provision of the care set out in the plan of care, outcomes of the care set out in the plan of care and the effectiveness of the plan of care.

The resident's written plan of care stated for the activation aide to engage the resident in an activity two to five times a week and invite and escort the resident to social programs. Activation aides were to document the resident's participation in activities. Over a two month period, there was only one documentation on a specified date to indicate that the resident was engaged in activities by an activation aide.

The Activation Aide did not document the activities that the resident was engaged in as set out in their plan of care. The Programs and Activities manager acknowledged the issue related to a lack of, and consistency in documentation by activity aides when they engaged residents in activities as per their plan of care.

Sources: Activity Pro documentation, progress notes, Activity Aide #129, Programs and Activities Manager #128 [s. 6. (9)]

4. The licensee has failed to ensure that when a resident was reassessed and the plan of care was reviewed and revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Resident #024 was assessed to be at risk for falls. The resident had nine falls within a two-month period without different falls interventions being considered. Six of these falls took place within a one month period with one of these falls resulting in injury. After the tenth fall during this two-month period, a new intervention was implemented.

The physiotherapist stated that the home was in outbreak during the month that the resident had six falls, which meant one of the effective interventions could not be implemented. The resident had also been moved to a different unit which increased their restlessness. The physiotherapist acknowledged that these changes would have been further reason to consider different approaches to prevent falls for this resident.

Sources: RN #132, Physiotherapist #127, Falls Risk Assessment, Post fall assessments, Risk management, Physiotherapist post fall assessments, Physiotherapist referrals [s. 6. (11) (b)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; and to ensure that when a resident is reassessed and the plan of care is being reviewed and revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 instituted or otherwise put in place was complied with related to the home's policy on falls prevention and management.

Resident #008 had a fall which resulted in an injury and a significant change in their status. There was no Morse Fall Risk assessment completed after the fall incident.

According to RN #112 and RPN #102, the home used the Morse Fall Risk assessment tool to reassess a resident with significant change and readmission from the hospital. They both confirmed that the resident was required to have the fall risk assessment after

their fall and did not have it.

The home's policy titled: Falls Prevention and Management Program, RC-15-01-01, last updated December 2019, indicated to screen all residents on admission or with a change in condition that could potentially increase the resident's risk of fall/fall injury using the fall risk assessment tool.

Sources: a review of the critical incident report, assessments, progress notes, plan of care, the home's policy and staff interviews. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with related to the home's policy on Management of Narcotic and Controlled Drugs.

A) A Critical Incident System (CIS) report indicated twenty-two tablets of a controlled substance were missing. During interviews with the day shift RPN #103 and the night shift RN #121, they both indicated that they did not complete the narcotic count at the shift change as per the home's expectations on an identified date. The DOC acknowledged that the registered staff did not comply with the home's policy on the Management of Narcotic and Controlled Drugs.

The home's policy RC-16-01-13, last updated December 2019, and March 2020, titled: Management of Narcotic and Controlled Drugs indicated that two nurses, one from the outgoing shift and one from the incoming shift, will count and sign-off on the narcotic and controlled substance count sheet every shift change; and
Document narcotic and controlled drugs on Master Narcotic and Controlled Substance Count Sheet link to 2 shifts/24 hours tool; and Individual Resident's Narcotic and Controlled Substances count sheet located in a separate binder.

B) The inspection sample was expanded to the following resident home areas:

i. Observation of medication administration was conducted on the resident home area West 2. Inspector #654 observed the day shift RPN #101 signing on the Master Narcotic and Controlled Substance count sheet at 1330 hours (Hrs). The RPN was also observed signing on the Individual Resident's Narcotic and Controlled Substances count sheet for a medication they had administered at 0800hrs and 1200hrs. RPN #101 confirmed the observations and stated that they should have signed off on the Master Narcotic and Controlled Substance count sheet at the beginning of the shift. They completed the drug

count with the registered staff from the outgoing shift but did not sign on it. They were also required to sign off on the Individual Resident's Narcotic and Controlled Substances sheet right after they had administered the medication to a resident as per the home's policy.

ii) Medication administration observation was conducted on the resident home area West 1. Inspector #654 observed at 1315hrs, RPN #100 signing on the Individual Resident's Narcotic and Controlled Substances count sheet for resident #003 and #004 for medication they had administered at 0800hrs and 1200hrs. The RPN indicated that they were required to document and sign on the count sheet right after they had administered the medication to residents as per the home's policy.

iii) Medication observation was conducted at 1355 hrs on the resident home area East 1. During the review of the narcotic count binder, and an interview with RPN #102, they confirmed that they did not sign on the Master Narcotic and Controlled Substance count sheet at the start of the shift. The RPN stated they had completed the count with a registered staff at 0700 hrs but did not sign on the sheet.

iv) Inspector #654 conducted an observation of narcotics and controlled substance count on the resident home area South 1, at 1500hrs. It was observed that RPN #109 did not sign on the Master Narcotic and Controlled Substance count sheet. During the interview, RPN #109 indicated that they had completed the narcotic count with the registered staff at 0700 hrs but had missed signing on the count sheet.

Interview with the DOC acknowledged that registered staff did not comply with the home's policy on Management of Narcotic and Controlled Drugs.

Sources: medication administration observations, a review of the CI, the home's investigation notes, residents' electronic medication records, narcotic count binders, and staff interviews. [s. 8. (1) (b)]

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 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 is complied with, to be implemented voluntarily.

WN #3: 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 used safe transferring and positioning devices or techniques to when a resident was assisted.

Two staff were to assist with transferring the resident using a specified transfer lift and an identified size sling with a specific colour.

The inspector observed PSW #133 sitting outside resident #025's room. Upon entering the room, resident #025 was observed in a different colour sling, hanging in the lift, hovering above their bed. There were no staff inside the room. The resident was heard moaning. PSW #133 stated that the resident was being toileted in this manner. The inspector called PSW #134 who helped to transfer the resident down.

RPN #134 had helped PSW #133 put the resident in the lift and left them with PSW #133 and was aware that the resident was being toileted in this manner.

It was a safety risk to leave the resident unattended hanging from a lift in a sling. The resident was not comfortable. Safe transferring and positioning devices and techniques were not used when assisting resident #025.

Sources: Plan of care, PSW #133, observations by inspector, RPN #134, PSW #134 [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and assistive aids part of the falls prevention and management program are readily available at the home.

According to RN #112 bed alarms and chair alarms were not readily available in the home for residents who needed it. This was confirmed by Physiotherapist #127 and the Falls Prevention Program lead RN #132. They were ordered after a resident was assessed to require one, during which time they would have to wait for its arrival.

An order was made for two bed alarms on November 9, 2020, and they arrived November 12, 2020, while another order was made July 8, 2020, for 8 bed alarms, and only one arrived August 5, 2020, as they were on back order. There had been no chair alarms ordered.

Sources: Invoices, Delivery Receipts, emails, Physiotherapist #127, RN #112, RN #132 [s. 49. (3)]

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 equipment, supplies, devices and assistive aids part of the falls prevention and management program are readily available at the home, to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that respects their dignity.

The resident was to be toileted in bed with total assistance by two staff.

The inspector observed PSW #133 sitting outside resident #025's room. Upon entering the room, resident #025 was observed in a sling, hanging in the lift, hovering above their bed with briefs on the bed below them. There were no staff inside the room. The resident was heard moaning. PSW #133 stated that the resident was being toileted in this manner.

RPN #134 indicated that they were aware that the resident was being toileted in this manner.

The resident's right to be be treated with courtesy and respect and in a way that fully respects the resident's dignity was not protected in relation to the method that was being used to assist them with toileting.

Sources: Plan of care, PSW #133, observations by inspector, RPN #134, PSW #134 [s. 3. (1) 1.]

Issued on this 5th day of January, 2021

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

Original report signed by the inspector.