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_0006	010984-20, 018326-20	Complaint

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 Complaint inspection.

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

The following intakes were inspected:
- log #010984-20 related to recreation and social activities
- and log #018326-20 related to medication administration

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_0007.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the plan of care related to a medication order.

The resident received a physician order for a specified medication. There was a second physician order dated seven days later for the dose of the specified medication to be increased. The resident had identified a family member as their SDM of care. The resident's SDM was not informed about the above-mentioned physician orders and did not provide consent to initiate the orders.

An RPN indicated that the resident's SDM was not informed about the above-mentioned physician orders before the administration of the medication. The DOC acknowledged that registered staff should have called and taken consent of the SDM before the administration of the medication.

Sources: a review of the resident's clinical file, physician orders, progress notes, and staff and SDM interviews. [s. 6. (5)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

The inspector attempted to interview a resident who indicated that their assistive aide had not been applied. The resident requested for their assistive aide to be applied. After the inspector informed an RPN of the resident's request, they applied the assistive aide to the resident's left side.

The resident's written plan of care stated that registered staff were to ensure that the resident's right side assistive aide was applied in the morning and removed at bedtime. The resident's right side assistive aide had been discontinued by the specialist approximately one month ago, and they were only supposed to be provided their left one. The resident's written plan of care was not updated to reflect this change.

The RPN did not offer the resident their assistive aide on the specified date, before the inspector's request. The home's practice was to include an order for the application of this type of assistive aides in residents' Electronic Medication Administration Records. The RPN had not been offering the assistive aide to the resident previously as there was no order for it in the resident's EMAR.

Sources: Resident #007's care plan, EMAR, progress notes, interviews with RPN #107, RPN #105, and RN #116 [s. 6. (10) (b)]

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.