Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 5, 2023	
Inspection Number: 2023-1072-0005	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Bayview, North York	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature** Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.10.17 14:46:11 -04'00'
Additional Inspector(s) Susan Semeredy (501)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 13, 14, 15, 18, 19, 20, 25, 26, 2023.
The inspection occurred offsite by Inspector #501 on the following date: September 22, 2023

The following intake(s) were inspected:

- Intake: #00096686 – Proactive Compliance Inspection.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
The resident's care plan indicated that the resident required a specific assistive device for ambulation.

Upon observation, the resident was ambulated from the shower room to their bedroom with the Personal Support Worker (PSW) assistance, however the assistive device was not used.

The PSW, and the Registered Nurse (RN) reported that the PSW implemented a new strategy to manage the resident's responsive behaviour which was not specified in the resident's care plan. The Director of Care (DOC) confirmed that the care plan did not provide clear instructions to direct staff to manage the resident's responsive behaviour.

On September 21, 2023, the resident's care plan was updated to reflect strategies to manage the resident's responsive behavior.

Sources: The resident's care plan, assessments interviews with the PSW, the RN and the DOC.

[741673]

Date Remedy Implemented: September 21, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee shall ensure that a 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 changed.

Rationale and Summary
The resident's care plan indicated to provide a specific staff assistance for a transfer.

An assessment was completed for the resident which indicated to use a specific staff assistance for the transfer. The resident's care plan did not identify that the resident was to receive this specific intervention.

The RN stated that the registered staff was responsible for updating the care plan to reflect the above-mentioned intervention. The DOC acknowledged that the assessment recommendation was not updated in the care plan.

The intervention to use specific staff assistance for transfers was updated in the care plan on September 20, 2023.

Sources: The resident's care plan, assessments, interviews with the RN, and the DOC.

[741673]

Date Remedy Implemented: September 20, 2023

WRITTEN NOTIFICATION: Residents' Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that residents were afforded privacy in caring for their personal needs.

Rationale and Summary
Residents #004 and #007 expressed that during care, they felt they were not afforded privacy and were not treated with dignity. Staff members would sometimes come in to speak with the PSW who was assisting with the care or would use the other side of the room to toilet another resident. Resident #007 made a statement to indicate their dignity and privacy was not maintained.

The Residents' Council meeting minutes in January 2023 indicated staff were still entering into resident's personal space during the provision of the care to talk to staff giving care, to get something or to bring a resident into the other side of the room to use the toilet. Residents stated in the meeting that this was very "invasive and uncomfortable."

Failing to uphold the Residents' Right to privacy risked endangering residents' emotional well-being.

Sources: Interviews with residents and minutes of the Residents' Council meeting minutes.

[501]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
The resident's care plan indicated that the resident required specific staff assistance for bathing.

During an observation, the PSW provided assistance to the resident during the shower activity.

The PSW acknowledged they provided care to the resident that did not align with the resident's care plan. The PSW was aware of the resident's care plan and confirmed that the care plan was not followed. The DOC confirmed that the resident required specific staff assistance to assist them for bathing due to their responsive behaviours. They acknowledged that the resident's care plan was not followed as required.

There was risk to the resident when care plan instructions were not followed during bathing related to the care needs identified in their care plan.

Sources: Resident's clinical records and progress notes, interview with the PSW, the DOC and other staff.

(741673)

WRITTEN NOTIFICATION: Quality

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee has failed to ensure that advice from the Resident's Council was sought in carrying out the Resident and Family/Caregiver Experience survey.

Rationale and Summary
The Residents' Council President stated that the Residents' Council was not consulted about the latest resident satisfaction survey. Residents' Council meeting minutes were reviewed for 2022 and 2023. There was no documentation that indicated the home sought the advice of the council in carrying out the satisfaction survey that was conducted from October 31 to December 20, 2022, or the one that will be conducted in 2023.

Interviews with the Program Services Manager who is the Residents' Council assistant and the Administrator indicated that Extendicare has created a corporate approach to involving residents with the resident and family satisfaction surveys which does not include the home's Residents' Council.

Sources: Residents' Council meeting minutes, interviews with the Residents' Council President, and staff of the home.

[501]

WRITTEN NOTIFICATION: Residents' Council

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

The licensee has failed to ensure that when the Resident's Council advised the licensee of concerns or recommendations, the licensee responded within 10 days to the Resident's Council in writing.

Rationale and Summary

The Residents' Council had concerns and suggestions regarding the home returning to single seating dining. The home did not respond to the Resident's Council within 10 days in writing.

Sources: Residents' Council meeting minutes for January 19, 2023, email communication between the Residents' Council assistant and the Administrator dated March 15, 2023, and an interview with the Residents' Council assistant.

[501]

WRITTEN NOTIFICATION: Safe and Secure Home

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 23 (1)

The licensee has failed to comply with the plan to prevent and manage heat related illness.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the license is required to ensure that there is a written heat related illness prevention and management plan that must be complied with.

Specifically, nursing staff did not comply with the Preventing and Managing the Heat Related Illness Reference Policy RC -08-01-04 A2. The plan states if the temperature is above the threshold 22 to 26 degrees nursing staff are to:

1. Discuss with residents about comfort level and intervene with a plan if resident advise.
2. Close windows, draw curtains during the day.
3. Move the residents to the cooling areas in the home.
4. Keep residents hydrated.
5. Dress residents appropriately.
6. Remove excess bedding.
7. Document the action taken in PCC.

Review of the home's temperature logs indicated:

- On September 5, 2023, the temperature in the resident's room was 28 degrees from 1700 to 1800 hours.

- On September 6, 2023, the temperature in the resident's room was 28 degrees from 1500 to 1600 hours.
- On September 15, 2023, the temperature in the resident's room was 28 degrees from 1300 to 2000 hours.

There was no documented action taken, if any, for the above-mentioned dates in their record related to the temperature of the rooms and the status of residents residing in these rooms which was confirmed by the RN. The Administrator acknowledged that the home did not follow their plan for preventing heat related illness.

Failing to follow their plan for preventing heat related illness put residents at risk.

Sources: The home's policy, temperature logs, resident records in PCC and interviews with RN and the Administrator.

[501]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)

The licensee has failed to ensure that a written record was kept of the evaluation by the registered dietitian (RD) who was a member of the staff of the home.

Rationale and Summary
The home was unable to produce a copy of the RD's evaluation of the home's menu cycle. The Dietary Manager stated the RD had made several suggestions and changes to the menu cycle, but the written record of this evaluation was inaccessible because it was only on the RD's computer. The RD was on vacation and unavailable due to being out of the country.

Sources: Lack of written record and interview with the Dietary Manager.

[501]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

The licensee has failed to ensure that all food in the food production system were served using methods to prevent food borne illness.

Rationale and Summary
The home's policy titled Temperatures of Food at Point of Service #NC-09-01-03, last revised January 2022, stated to record the temperature on the Food Temperature Record or another appropriate form and when the temperature is outside the normal range to contact the cook for assistance to reheat or cool menu item.

Point of Service Food Temperature Records for the week of September 11-17, 2023, defined normal temperature of hot food to be 60 degrees Celsius or 140 degrees Fahrenheit and cold food to be 4 degrees Celsius or 40 degrees Fahrenheit. Review of these logs indicated all cold food temperature was either 4 degrees Celsius or 40 degrees Fahrenheit and there is never any range. As well, most days the temperatures were being taken for the same meal in both Celsius and Fahrenheit. For example, on Monday, September 11, 2023, the temperatures for all hot foods were taken in Fahrenheit and the cold foods had a temperature in Celsius.

The Dietary Aide took the temperatures of food items at the steam table before serving the lunch meal but did not record the temperatures anywhere. The Dietary Aide later confirmed that they knew they should have recorded the temperatures but had forgotten. Dietary Aides #106 and #107 when observed serving food items for tray service at lunch, took temperatures of the cold food. When these temperatures were not within normal ranges, they did not know what to do. Many of the desserts on both days had already been served on trays for residents who were in isolation. One dessert item, baked custard, was found to be at 53 degrees Fahrenheit.

The Dietary Manager acknowledged that the point of service temperature logs implied the temperatures of the cold food were not being taken as there was never any range and almost always changed to Celsius with the temperature of 4 being most prevalent. Since cold food temperatures only deviated when the Inspector was making observations, the Dietary Manager suspected that the temperatures on the logs were being fabricated.

Failing to accurately take the temperature of food items and record them accurately put all residents at risk for food borne illness.

Sources: Observations, home's policy and food temperature logs, and interviews with the Dietary Manager and other staff.

[501]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program related to Personal Protective Equipment (PPE).

Rationale and Summary
A resident was on isolation precautions. The resident's door had donning/doffing posters to provide visual messages about recommended additional precautions and sequence for putting/removing Personal protective Equipment (PPE).

On an identified date, the PSW was observed incorrectly doff recommended PPE upon exiting the resident's room who was on isolation precautions.

The PSW acknowledged that they did not follow correct doffing sequence upon exiting the resident's room who was on isolation precautions. The DOC acknowledged that for the above-mentioned observation, the PSW did not implement appropriate IPAC practices.

There was risk of infectious disease transmission when the correct doffing procedure was not followed.

Sources: Review of Minister's Directive: COVID-19 response measures for LTCHs, effective April 30, 2022, COVID-19 Guidance Document for LTCHs in Ontario, Donning/Doffing PPE signage, home's additional precautions policies and procedures, interviews with the PSW and the DOC.

[741673]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act using the Critical Incident Report (CIR) system.

Rationale and Summary
The home was declared in a confirmed outbreak in September 2023. A CIR was submitted to the Director related to confirmed outbreak two days after it was confirmed. The confirmed outbreak was not reported to the Director immediately through after-hours reporting system.

The DOC was aware that confirmed outbreak was required to be reported immediately and confirmed that the Director was not notified immediately.

There was no risk to residents when the confirmed outbreak was not reported to the Director.

Sources: CIS report, and interview with the DOC.

[741673]

WRITTEN NOTIFICATION: Quality

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to ensure that a report was prepared on the continuous quality improvement initiative for the home and was published on their website.

Rationale and Summary
The home published a report titled “Extendicare Quality Improvement Plan 2023” to its website on September 18, 2023, which the Administrator stated was to reflect their quality program at the home. The report contained Extendicare’s overall organizational priorities for quality improvement but was not specific to the home.

The report lacked the following requirements:

- The name and position of the designated lead for the home’s continuous quality improvement initiative.
- The home’s priority areas for quality improvement for the next fiscal year. The report contained Extendicare’s priority areas as an organization. The priority areas were not based on the recommendations of the home’s continuous quality improvement committee.
- The date the resident and family satisfaction survey were taken (October 31 to December 20, 2022) or the results.

- How, and the dates when, the results of the survey were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.
- The actions taken to improve the long-term care home, and the care, services, programs, and goods based on the documentation of the results of the survey.
- What role the Residents' Council and Family Council had in actions taken.
- How improvements were communicated to families and residents.
- That a copy of the report was provided to the Residents' Council and Family Council.

The Administrator stated they were in communication with Extendicare corporate and will be updating the report with home specific details. They indicated that many of the activities had been completed but were not compiled in a report format as required.

Sources: The home's report on the continuous quality improvement initiative and an interview with the Administrator.

[501]