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: August 6, 2024

Inspection Number: 2024-1072-0002

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Bayview, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 19, 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00112969/Critical Incident (CI), related to an injury with unknown cause;
- Intake: #00115629/CI, related to a fall with injury and allegation of abuse and;
- Intake: #00115993/CI, related to improper care causing injury.

The following intake(s) were completed:

- Intake: #00112517/CI and,
- Intake: #00120777/CI, both related to falls with injury.

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

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Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their falls prevention and management program to reduce the risk of injury to a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a falls prevention and management program to reduce the risk of injury and must be complied with.

Specifically, staff did not comply with their policy on post fall management which was included in their Falls Prevention and Management Program.

Rationale and Summary

The home's post fall management procedures stated that residents will be assessed post fall by a nurse prior to any transfer or assistance to ambulate.

The home submitted a critical incident (CI) to the Ministry of Long-Term Care (MLTC) related to a fall of a resident, where they sustained an injury.

A Personal Support Worker (PSW) discovered the resident on the floor with a family member and left the resident to get assistance. Another PSW went to the resident to provide additional assistance and found the resident was transferred to their bedside commode. The PSWs acknowledged that staff were to stay with the resident post fall to ensure they were not transferred until assessed by the nurse, as per the home's falls program.

A Registered Nurse (RN) and the Falls Lead both acknowledged that the PSW who discovered the fall should have stayed with the resident post fall to ensure that the resident was not transferred until assessed by the nurse to reduce the extent of injury.

There was a risk of further injury to the resident when they were transferred post fall prior to being assessed by the registered staff.

Sources: Review of CI report, a resident's clinical records and Falls Prevention and Management Program Policy #RC-15-01-01, Last Reviewed March 2023 and; interviews with PSWs, RN, Falls Lead and other staff.

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Conduct weekly audits on a particular shift for three weeks to ensure a resident's fall intervention is implemented as per the plan of care upon service of this report.

2) Maintain a record of the audits conducted, the auditor(s), date and times of the audits, results of the audits and any actions taken to address the audit findings.

3) Provide an identified PSW a review of the home's process when a fall intervention is required by residents upon service of this report.

4) Maintain a record of the review conducted, date of the review and the staff that provided the review.

Grounds

The licensee has failed to ensure that the care set out in the plan of care were provided to two residents as specified in the plan.

Rationale and Summary

(A) A PSW discovered a resident with areas of altered skin integrity at the start of

their shift. This was immediately reported to the registered staff for assessment.

The resident's plan of care indicated they required total assistance by two staff and an intervention for continence care.

The home's investigation notes indicated that on the previous shift prior to the discovery of the altered skin integrity, another PSW provided care to the resident independently. This was substantiated by the home's review of their video surveillance.

This PSW acknowledged they independently provided care to the resident and did not implement the intervention for continence care.

The Director of Care (DOC) acknowledged that the resident's plan of care was not followed by the PSW when they provided care to the resident.

Staff failure to follow the resident's plan of care presented a risk to the resident.

Sources: Review of home's video surveillance footage, a resident's clinical records, home's investigation notes; and interviews with an RN, PSW, DOC, and other staff.

Rationale and Summary

(B) Another resident had a fall and sustained an injury. The CI indicated that a fall intervention was not implemented at the time of the fall.

The resident was assessed as a fall risk and the plan of care indicated they had additional supply of a fall intervention. A PSW indicated they provided care to the resident, did not find the fall intervention, and did not report it to the registered staff.

The PSW acknowledged that the resident was a fall risk, and they did not follow the resident's plan of care to manage their falls.

The Falls Lead acknowledged that the PSW should have informed the nurse so that the fall intervention could have been provided to the resident. They indicated that the PSW did not follow the resident's plan of care to manage their falls.

Failure to implement the fall intervention may have contributed to the extent of injury the resident sustained from their fall.

Sources: Review of CI Report, a resident's clinical records and; interviews with a PSW, Falls Lead and other staff.

This order must be complied with by September 16, 2024

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.