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 15, 2024
Inspection Number: 2024-1072-0003
Inspection Type: Complaint Critical Incident Follow up
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): October 2, 3, 4, 8, 9, 2024
The inspection occurred offsite on the following date(s): October 7, 2024
The following intake(s) were inspected in Critical Incident System (CIS) inspection:
• Intake: #00123334 - Follow-up CO #001 - FLTCA, 2021 - s. 6 (7) from inspection #2024-09-16
• Intake: #00123502/CIS#2460-000014-24 related to resident falls.
• Intake: #00125229/CIS# 2460-000015-24 related to resident abuse.
• Intake: #00125973 related to complaint involving resident abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

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Order #001 from Inspection #2024-1072-0002 related to FLTCA, 2021, s. 6 (7) inspected.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
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,
(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.

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care for resident when they had a change in health status.

Rationale and Summary
A resident's clinical records revealed that the resident was found with an injury. As

per the resident's clinical records, a Registered Practical Nurse (RPN) completed a health assessment; however, they failed to inform the charge nurse. The resident was sent to the hospital, for further assessment.

The Registered Nurse (RN) acknowledged that they expected staff to notify them of any changes in a resident's health condition, however, the RPN did not inform them on the day that the injury was found, and the RN was only made aware at the end of their shift on date sent to the hospital.

The RPN failed to collaborate with the RN when resident's health condition changed, which increased the risk of delayed treatment and interventions.

Sources: Resident's clinical records, interviews with the staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
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.

The licensee has failed to ensure that the resident's Power of Attorney (POA) was given the opportunity to participate fully in the development and implementation of the plan of care when new treatment was ordered for the resident.

Rationale and Summary

A resident was found with an injury. In review of the resident's progress notes, there was no POA notification documented related to the resident's change in health status.

The DOC acknowledged that staff were expected to inform resident's POA when there is a change in resident's health condition and acknowledged that the resident's POA was not given the opportunity to participate fully in the development and implementation of the plan of care.

Failure to notify resident's POA regarding their change in health status prevented them from fully participating in the plan of care.

Sources: Resident's clinical records, interviews with the staff.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
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,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and that their plan of care was reviewed and revised at the time that resident did not want the intervention as outlined in their care plan.

Rationale and Summary

A PSW stated that a resident did not want a specified equipment and would remove it.

The resident's care plan identified that the resident required this intervention as a falls prevention intervention.

The RPN acknowledged that they aware of the resident's tendency to remove the intervention and also said that this information was verbally reported to the RN to update it in the resident's care plan. The RN acknowledged that the plan of care should be updated if the interventions set out in the care plan were no longer needed.

Sources: Observation, review of resident's records and information received from the staff, interviews with the staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with their policy to promote zero tolerance when alleged abuse was reported to staff related to resident.

Rationale and Summary

A RPN discovered a resident with an injury. The resident's family member alleged that staff were responsible for causing the resident's injuries.

The home's zero tolerance of resident abuse and neglect, investigation and consequences policy directed that all reported incidents of abuse and/or neglect will be objectively, thoroughly and promptly investigated in keeping with the steps outlined in the Workspace Investigation Toolkit.

DOC acknowledged that the alleged incident was not thoroughly investigated by the home as per home's policy.

Sources: Resident's clinical records, home's policy titled "Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences " policy #RC-02-01-03 last reviewed November 2023, interviews with the staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of abuse related to resident's injuries was reported to the Director immediately.

Rationale and Summary
A resident was found with an injury. The resident's family member alleged that the resident's injuries were caused by home staff.

The CIS report was submitted to the Ministry of Long-Term Care (MLTC) sixteen days later. During an interview with the DOC, they acknowledged that the home submitted the report of alleged abuse and should have been immediately reported.

Failing to immediately report the incident of alleged abuse put the resident at risk for further harm as the Director could not respond to ensure appropriate measures had been taken to prevent reoccurrence.

Sources: CIS #2460-000015-24, interview with the DOC.

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.
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:
4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to comply with their pain management program when new pain was identified for resident.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee was required to ensure that the pain management program included implementation of policies and

procedures relating to communication and assessment methods for residents who are cognitively impaired and was complied with

Specifically, staff did not comply with the LTCH's pain identification and management policy when the resident's pain was not assessed using the comprehensive pain assessment.

Rationale and Summary
The home's pain identification and management policy directed staff to assess the resident for new pain using the comprehensive pain assessment in addition to the use of the Pain Assessment in Advanced Dementia (PAINAD) to assess all non-verbal and cognitively impaired residents.

A RPN discovered a resident with an injury, however the RPN did not complete a pain assessment. RPN found that the resident showed verbal and nonverbal indicators of pain, however a pain assessment was not completed by registered staff.

Two RPNs acknowledged that the resident was in pain and that a pain assessment was not completed. DOC acknowledged that registered staff failed to complete pain assessments when the resident was experiencing pain and implementing appropriate interventions.

Failure to complete pain assessments on the resident increased the risk of not identifying the severity of the resident's pain.

Sources: Resident's clinical records, home's policy titled "Pain Identification and Management" policy #RC-19-01-01 last reviewed March 2023, interviews with staff.

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