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

Public Report

Report Issue Date: December 11, 2024
Inspection Number: 2024-1072-0004
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): December 3 to 6, 2024

The following critical incident (CI) intake(s) were inspected:
-Intake: #00128951 was related to abuse
-Intake: #00129377 was related to a fall resulting in injury.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect resident #002 from sexual abuse by resident #003.

Section 2 of Ontario Regulation 246/22 defines sexual abuse as any non-consensual touching, behaviour, or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale Summary:
Resident #002 and resident #003 were found in resident #002's room in a state of undress.

The home's investigation indicated that resident #002 reported that resident #003 tried to initiate sexual activity with them and were later found by staff. Resident #002 confirmed they did not consent to sexual activity with resident #003.

The Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed resident #002 could give consent.

Failing to protect resident #002 from sexual abuse by resident #003 might have caused physical and emotional harm to resident #002.

Sources: Residents' clinical records, interviews with ADOC and DOC, and home's investigation notes.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

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

The Licensee shall:

a) complete 4 audits of an identified Personal Support Worker (PSW) transferring residents who require 1-person assistance using an assistive device.

b) document the following in the audits: date and time of audit, auditor name, resident name, whether the PSW selected the appropriate device(s) and used safe techniques to assist the resident with transferring and any corrective actions taken in response to the audit findings.

c) make the audit record immediately available to the Inspectors upon request.

Grounds

The licensee failed to ensure that a PSW used a safe transferring device and technique when assisting a resident.

Rationale and Summary

A resident fell while being assisted with transferring by a PSW.

The resident was tired so they sat on a mobility device then the PSW pushed the device to transfer the resident. The resident fell while the device was being pushed, resulting in an injury and hospitalization.

The PSW acknowledged that they pushed the mobility device while the resident was seated and it was unsafe. Several staff acknowledged that the transfer technique was unsafe and it increased the risk and impact on the resident.

Failure to use a safe transferring device and technique while assisting the resident resulted in a fall with an injury.

Sources

Resident's care records, risk management report, interviews with PSW, Registered Nurse, Physiotherapist and Director of Care.

This order must be complied with by January 20, 2025

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.