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
Feb 4, 2020	2020_650565_0002	013244-19, 013893-19, 016640-19, 018496-19, 019512-19, 022966-19, 023676-19	Critical Incident System

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

MATTHEW CHIU (565), NAZILA AFGHANI (764)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 20, 21, 22, 23, 24, 27, and 28, 2020.

The following intakes were completed in this Critical Incident System (CIS) Inspection:
- #013244-19, #013893-19, #016640-19, #018496-19, #022966-19, #023676-19 related to falls prevention, and
- #019512-19 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), and Residents.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
2 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. (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. 2007, c. 8, s. 6 (7).

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 the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

Review of a CIS report indicated resident #001 had an identified personal care condition on an identified date. PSW #101 did not provide a specified care to the resident and took them to the identified home area for attending an activity. When resident #001's family member visited the resident during the activity, they discovered the resident's personal care condition. PSW #101 told the family member that they had not provided the specified care for the resident.

Review of resident #001's plan of care indicated they had both cognitive and physical impairments. At the time of the above-mentioned incident, the resident had an identified health condition and required a specified care. The plan further stated a specified intervention when resident #001 has an identified responsive behaviour that may impact care being provided.

Review of the home's investigation records indicated on the identified date and time, PSW #101 went to resident #001's room to provide the specified personal support assistance to the resident. The PSW observed resident #001 with the identified personal care condition and wanted to provide the specified care for the resident. PSW #101 stated the resident demonstrated the responsive behaviour, and therefore they took the resident to attend the activity without providing the specified care. The resident's family member visited the resident during the activity, discovered the resident's personal care condition, and took the identified action.

Interview with PSW #101 indicated that on the identified date and time, they went to resident #001's room and saw the resident's identified personal care condition. PSW #101 stated they attempted to provide the specified care for resident #001 but the resident demonstrated the responsive behaviour. The PSW further stated a specified situation had happened and they took the resident to the identified home area. PSW #101 admitted they did not provide the specified care to the resident.

Interview with RN #102 stated that if the resident required the specified care and demonstrated the responsive behaviour, the PSW should use the specified intervention for managing their behaviour to provide the specified care.

Interview with the Administrator indicated that resident #001's plan of care directed staff to provide the specified care to the resident. When PSW #101 found resident #001 with the identified personal care condition, the specified care should be provided to the resident. If the resident demonstrated the behaviour, PSW #101 should have used the specified intervention for the behaviour. The Administrator stated on the above-mentioned date, resident #001 was taken to the identified home area without being provided with the specified care. The Administrator acknowledged that the specified care set out in resident #001's plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that resident #004's plan of care was revised at any other time when the care set out in the plan has not been effective.

A CIS report was submitted to the Ministry of Long-Term Care (MLTC) related to resident #004's identified fall that the resident was taken to the hospital and diagnosed with a significant injury.

Record review indicated resident #004 had mild cognitive impairment and required the specified assistance for locomotion. The resident was at risk for falls and their falls prevention plan of care was last revised after the above-mentioned fall. Further review of the resident's falls history indicated they had five identified falls after the plan was revised.

Interviews with PSWs #106, #111 and #114, indicated they were aware that resident #004 sustained multiple falls and they were at risk for falls. Interviews with RNs #104 and #107 indicated resident #004 sustained the above-mentioned falls and their falls

prevention plan was last revised on the identified date. The staff members stated they started a specified intervention, but they did not recall when exactly it was implemented. RN #107 further stated resident #004's falls prevention plan was not effective preventing their falls due to the specified care issue.

During an interview with ADOC #110, they stated that resident #004's falls prevention plan of care has not been effective as the resident continued to fall. The ADOC further stated after the resident's fall and reassessment, the team should implement strategies and revise the falls prevention plan when it has not been effective. ADOC #110 acknowledged that the care set out in resident #004's fall prevention plan was not revised as required. [s. 6. (10) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that:
- the care set out in resident's plan of care is provided to the resident as specified in the plan, and
- resident's plan of care is revised at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe positioning devices or techniques when assisting resident #002.

A CIS report was submitted to MLTC related to resident #002’s identified fall. The resident was transferred to the hospital and diagnosed with a significant injury.

Record review indicated resident #002 had both physical and cognitive impairments. The resident required the specified assistance for locomotion using wheelchair and was at risk for falls related to their identified health condition.

Interviews with PSW #103 and RN #104 indicated that the above-mentioned fall occurred when resident #002 was transported in wheelchair without the specified positioning devices. The staff members further stated due to resident #002’s specified known habit, the specified positioning devices were removed when they were in the wheelchair.

Interview with PT #109 indicated on an identified date, a new wheelchair with the specified positioning devices was given to resident #002. PT #109 stated the specified safe positioning technique for transporting resident #002 in wheelchair. The specified positioning devices should not be removed from the wheelchair when transporting the resident at all times.

Interview with ADOC #110 indicated that when resident #002 was transported in wheelchair by staff, they should be positioned using the specified positioning devices for safety. ADOC #110 and the Administrator stated they were aware that the specified positioning devices in the wheelchair were not being used for positioning resident #002 when the above-mentioned fall happened. They acknowledged that staff did not use safe positioning technique when transporting resident #002 in the wheelchair, as required. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 5th day of February, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.