Ontario

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

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

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: March 22, 2024	
Inspection Number: 2024-1072-0001	
Inspection Type: Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Bayview, North York	
Lead Inspector Nrupal Patel (000755)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13-15, 18-19, 2024.

The following intake(s) were inspected in this Critical Incident (CI) Inspection:

· Intake #00102554 / CI #2460-000018-23 , Intake #00104502 / CI #2460-000019-23, Intake #00105495 / CI #2460-000001-24, Intake #00107837 / CI #2460-000004-24 - related to disease outbreak.

· Intake #00106362 /CI #2460-000003-24 - related to falls prevention and management.

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

Infection Prevention and Control
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 (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 licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:

A resident's care plan indicated that they required two person assistance for bed mobility and continence care.

A Personal Support Worker (PSW) provided continence care alone while the resident was in bed, when the resident had a fall. As a result of the fall, the resident sustained an injury and was transferred to the hospital.

The PSW and a DOC (Director of Care) confirmed that two-person assistance was not provided as indicated in their plan of care.

When staff failed to provide the required assistance to the resident as per their plan of care, the resident sustained a fall with an injury.

Sources: Resident's care plan; and interviews with PSW and DOC.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

Rationale and Summary:

On March 14, 2024, a PSW was observed providing beverages and snacks to resident but did not assist with hand hygiene before eating and drinking.

The Home's Hand Hygiene Policy directs staff to encourage and/or offer assistance to residents to properly wash or sanitize their hands before and after meals or snacks.

The PSW confirmed that they did not encourage or assist the resident in performing hand hygiene before serving the snack.

The IPAC Manager and DOC acknowledged that staff must assist resident with hand hygiene before snacks.

Failure to assist the resident with hand hygiene before snacks put them at risk for infection.

Sources: Observation on an occasion; Interviews with PSW, IPAC Manager and the DOC; the home's Hand Hygiene Policy (IC-02-01-08, last updated January 2024)

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