Ontario

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

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 10, 2023

Inspection Number: 2023-1072-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

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

Lead Inspector	**Inspector Digital Signature**
Rajwinder Sehgal (741673)	Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.05.11 13:08:18 -04'00'

Additional Inspector(s)
Atala Katel (000705)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2, 4, 5, 8, 2023
The inspection occurred offsite on the following date(s): May 3, 2023

The following intakes were inspected in this complaint inspection:
- Intake: #00084471 related to concerns with falls prevention and management.

The following intakes were inspected in the Critical Incident System Inspection:
- Intake: #00022421 – [IL-10965-AH/2460-000007-23] related to falls.

The following intake(s) were completed in the Critical Incident System Inspection:
- Intake: #00086132 – [CI:2460-000010-23] related to falls.

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)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The resident's plan of care indicated that specific falls prevention interventions and measures should be in place. On an identified date, it was observed that the resident's specific intervention was not in place and the measure was not provided.

Personal Support Worker (PSW) acknowledged that they forgot to apply the specific fall prevention intervention for the resident and was not aware that the measure was not in place either.

Assistant Director of Care (ADOC) acknowledged that the resident's plan of care was not followed.

Failure to provide fall intervention as set out in the resident's plan of care placed the resident at risk of fall and injury.

Sources: Observations, resident's health records, interviews with PSW and ADOC.

[000705]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with their Falls Prevention and Management policy related to clinical monitoring record.

In accordance with O. Reg. 246/22, s.11 (1) (b), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents and must be complied with.

Specifically, staff did not comply with the home's policy "Clinical monitoring Record" dated January 2023

which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary
A resident had a fall on an identified date, resulting in injuries.

Review of the resident's clinical records indicated clinical monitoring was initiated post fall, however, one check was not completed as per the home's policy.

Registered Practical Nurse (RPN) indicated that the expectation was to complete clinical monitoring in the time frames as per the home's policy.

ADOC indicated that it was expected that all scheduled times on the clinical monitoring record were completed as per the schedule. They acknowledged that one of the checks for clinical monitoring was not completed.

Failure to complete clinical monitoring in accordance with the home's policy, placed the resident at risk for not properly being assessed for post fall complications.

Sources: Review of the home's policy "Falls Prevention and Management Program" #RC-15-01-01 dated January 2023, resident's care plan, progress notes, assessments, interviews with RPN, and ADOC.

[741673]