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
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Telephone: (866) 311-8002

Original Public Report

Report Issue Date: March 10, 2023	
Inspection Number: 2023-1072-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Bayview, North York	
Lead Inspector Susan Semeredy (501)	**Inspector Digital Signature** Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2023.03.13 10:56:00 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 27-28, March 1-3, 7-8, 2023.

The following intake(s) were inspected:
Intake: #00017802 - Complaint regarding neglect of a resident.
Intake: #00017824 - Resident sustained injury of unknown cause.
Intake: #00020135 - Resident to resident abuse resulting in injury.

The following intakes were completed related to resident care and support services:
Intake: #00014823 - Resident sustained injury of unknown cause.
Intake: #00018204 - Resident sustained injury of unknown cause.

Inspector Ann McGregor (000704) was present February 27, 28, March 1, 2, 3, 2023.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when the resident's care needs changed.

Summary and Rationale
A resident was found to have an injury of an unknown cause. The resident was sent to the hospital and was diagnosed with an injury. Prior to this incident, the resident was independent of mobility and used an assistive device. When the resident returned from the hospital, their assistive device was not to be accessible as it was unsafe for them to use. The resident's care plan was not revised to indicate this change.

Failing to revise the resident's plan of care put the resident at risk for further injury as care givers might be unaware of the resident's change in status.

Sources: Critical Incident (CI) report, observations, and interviews with staff. [501]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse that resulted in harm or risk of harm to resident #002 by resident #003 was immediately reported to the Director.

Summary and Rationale
The home submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MLTC) as an incident that caused an injury to a resident for which the resident was taken to hospital, and resulted in a significant change in the resident's health status. According to the DOC, the injury was from an altercation between resident #002 and #003 that occurred several days prior. No injuries were noted at the time of the altercation, but interviews confirmed there was a risk of harm. An actual injury was discovered the day before it was reported to the MLTC. The DOC acknowledged that this was an incident of suspected resident to resident abuse that resulted in risk of harm and should have been reported as such or immediately when actual harm in the form of an injury was determined.

Sources: CI report and interviews with the DOC and other staff. [501]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist staff who were at risk of harm or who were harmed as a result of resident #002's behaviours, and to minimize the risk of altercations and potentially harmful interactions between resident #002 and #003.

Summary and Rationale
Residents #002 and #003 had an altercation, which was witnessed. Even though there were no injuries noted at the time, there was a risk of harm as it resulted in resident #002 landing on the floor.

A few days later, a PSW attempted assisting resident #002 with an activity of daily living (ADL). The resident was expressing responsive behaviours and physically lashed out at the PSW. Later that day, the PSW noted altered skin integrity. It was at this time, the resident was noted to have pain and was subsequently diagnosed to have an injury. It was not clear whether the injury occurred from the resident-to-resident altercation or from the incident with the PSW.

Interviews indicated resident #003 had responsive behaviours and was triggered by resident #002. There were indications that resident #003 would physically lash out at resident #002. There was no mention of these incidents or interventions to address these behaviours in resident #003's plan of care.

Interviews indicated resident #002 had responsive behaviours. Progress notes indicated the resident had

a particular resistance towards an ADL. This resistance was noted to have occurred in the above two incidents, one involving resident #003 and the other involving the PSW. Resident #002's plan of care did not indicate this resistance and therefore did not include strategies to manage the behaviour.

Interviews indicated there was no in-house behaviour support team and the home relied on referrals to behaviour outreach programs. An ADOC acknowledged triggers and interventions for residents #002 and #003's responsive behaviours had not been identified.

Residents and staff were at actual risk for harm due to the home failing to ensure procedures and interventions were developed and implemented to manage both residents' behaviours.

Sources: Clinical health records for residents #002 and #003 and interviews with the ADOC and other staff. [501]