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
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: October 26, 2022
Inspection Number: 2022-1309-0002
Inspection Type: Follow up Critical Incident System
Licensee: Baycrest Hospital
Long Term Care Home and City: The Jewish Home for the Aged, North York

Lead Inspector	**Inspector Digital Signature**
Joy Ieraci (665)	Maria Joy Ieraci Digitally signed by Maria Joy Ieraci Date: 2022.11.10 13:39:43 -05'00'

Additional Inspector(s)
Kim Lee (741072)
Kehinde Sangill (741670)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 26 to 29, October 3, 4, 5 (off site), 6, 7, 11 to 13, 2022.

The following intake(s) were inspected:

- Log #00003919 (Follow-up) related to infection prevention and control;
- Log #00003521 (CIS #2824-000081-21) related to an injury of unknown cause;
- Log #00003039 (CIS #2824-000046-21]) related to skin and wound;
- Logs #00003200 (CIS #2824-000034-21) and #00004182 (CIS #2824-000041-21) related to abuse and;
- Logs #00002082 (CIS # 2824-000068-22), #00005795 (CIS #2824-000038-22) and #00003660 (CIS #2824-000043-21) were related to falls.
- The following intakes were completed in the Critical Incident System (CIS) Inspection: Logs #00001138 (CIS #2824-000076-21), #00001495 (CIS #2824-000095-22), #00003113 (CIS #2824-000029-21), #00002732 (CIS #2824-000057-22), #00003748 (CIS #2824-000042-21), #00005034 (CIS #2824-000105-22), #00005216 (CIS #2824-000003-22), #00005381 (CIS # 2824-000008-22), #00004168 (CIS #2824-000027-22) and #00006995 (CIS #2824-000025-22) were related to falls.

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Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O.Reg. 246/22	s. 102 (8)	2022-1309-0001	#001	(741072)

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

Infection Prevention and Control
Falls Prevention and Management
Safe and Secure Home
Prevention of Abuse and Neglect
Skin and Wound Prevention and Management
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of care for a resident collaborated with each other in the implementation of the plan of care related to falls prevention.

The resident's care plan indicated they required a device as a fall intervention. A different device was observed, which was verified by a registered practical nurse (RPN).

The occupational therapist (OT) stated they had assessed the resident for the required device to minimize concerns during the night from the use of the different device.

The required device was implemented by the OT seven days later.

Sources: Resident room observations; review of the resident's clinical records; and interviews with the RPN, OT and other staff.

Date Remedy Implemented: October 4, 2022
[741670]

NC #02 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 12 (1) 3

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

The doors leading into and out of one resident home area (RHA), were open and not supervised by staff. The RHA was a behavioural unit and the doors led into a common area. No residents were observed in the vicinity at the time of the observation.

A personal support worker (PSW) closed the doors immediately. A registered nurse (RN) indicated that the RHA was a secure unit, and the common area was a non-residential area, and the doors were to be kept closed.

Sources: RHA observation and interviews with the PSW and RN.

Date Remedy Implemented: September 27, 2022
[741072]

NC #03 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22 12 (1) 3

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when not supervised by staff.

The spa room door in one RHA, was observed open and unlocked. No residents were observed in the

vicinity at the time of the observation.

A RPN closed the door immediately. The RPN indicated that the spa room door was a non-residential area and was to remain closed for resident safety.

Sources: Spa room observation, and interview with the RPN.

Date Remedy Implemented: October 7, 2022
[741072]

WRITTEN NOTIFICATION: Police Record Checks

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 215 (8) 1.

The licensee has failed to ensure that before hiring a staff member, a signed declaration was obtained disclosing: i. Every offence with which they have been charged under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada) and the outcome of the charge; ii. Every order of a judge or justice of the peace made against them in respect of an offence under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada), including a peace bond, probation order, prohibition order or warrant to arrest and; iii. Every offence of which they have been convicted under the Cannabis Act (Canada), the Criminal Code (Canada), the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada).

Rationale and Summary

The home submitted a CIS report to the Ministry of Long-Term Care (MLTC) for an allegation of staff to resident abuse.

A PSW was employed in the home for about four and half months. The Program Director, Labour Relations indicated that the PSW did not a sign a declaration of any offences and charges before hire.

Failure to obtain a signed declaration of offenses and charges prior to hiring posed a risk to the safety of the residents in the home.

Sources: Review of the CIS report and the PSW's human resources file; and interview with the Program Director, Labour Relations. [665]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #05 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary

The home failed to fully implement the hand hygiene program in accordance with the "IPAC Standard for Long-Term Care Homes, April 2022". Specifically, that the hand hygiene program included 70-90% alcohol-based hand rub (ABHR) as required by Additional Requirement 10.1 under the IPAC standard.

Observation on October 4, 2022, found five bottles of ABHR expired at the main entrance of the LTCH.

A Screener and the Screener Supervisor verified that the ABHR were expired.

The main entrance was a common area, accessed by residents, staff, and visitors. The use of expired ABHR reduced the effectiveness of the ABHR used in the hand hygiene program.

Sources: Observation on October 4, 2022; review of ABHR expiration dates, and review of IPAC Standard for Long-Term Care Homes, dated April 2022; and interviews with the Screener and Screener Supervisor. [741072]

WRITTEN NOTIFICATION: Binding on Licensees

NC #06 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to the long-term care home (LTCH),

the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes was complied with.

In accordance with the Directive, licensees were required to ensure that the COVID-19 screening requirements set out in the COVID-19 Guidance Document for Long-Term Care Homes was followed.

Rationale and Summary

In accordance with the measures outlined in the MLTC COVID-19 Guidance Document for LTCHs in Ontario, residents were to be assessed at least once daily for signs and symptoms of COVID-19 including temperature checks.

A resident did not have daily temperature checks for 24 out of 33 days reviewed between two consecutive months.

A RPN stated that resident temperature checks were required daily and that the temperature checks were not always done.

There was moderate risk to the resident and other residents because this would have affected the ability to identify a change in the resident's status, related to COVID-19.

Sources: Review of Minister's Directive: COVID-19 response measures for long-term care homes, dated August 30, 2022, MLTC COVID-19 Guidance Document for LTCHs in Ontario, dated September 1, 2022, and review of the resident's clinical records; and interviews with the RPN and other staff. [741072]

WRITTEN NOTIFICATION: Plan of Care

NC #07 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 related to fall prevention interventions.

Rationale and Summary

The resident was at risk of falls and required a device in their wheelchair, which was to be in working

condition.

On two separate observations on the same day, the resident was sitting in their wheelchair with the device not in working condition.

A PSW acknowledged that the device was not working and had not worked since the previous week. Another PSW acknowledged that the resident required the device as a fall prevention intervention.

Failure to ensure that the resident's device was in working condition puts the resident at risk of not receiving timely intervention in the event of a fall.

Sources: Resident observations; review of the resident's clinical records; and interviews with the PSWs and other staff. [741670]

COMPLIANCE ORDER CO #01 Transferring and Positioning Techniques

NC #08 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36

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

The Licensee has failed to comply with O Reg 79/10 s. 36

The licensee shall:

1. Conduct audits on five residents requiring transfers with a mechanical lift on a specified resident home area, to ensure staff use safe transferring and positioning devices and techniques. The audits are to be conducted weekly for three weeks following the service of this order.

2. Maintain a record of the audits, including but not limited to, the date, person conducting the audits, staff and residents audited, results of the audits and any actions taken in response to the audit findings.

Grounds

The licensee has failed to ensure that staff used safe transferring and positioning devices and techniques

for a resident.

Rationale and Summary

The home submitted a CIS report to the MLTC in 2021, for an injury of unknown cause to a resident.

The resident required a mechanical device with the assistance of two staff for transfers.

A PSW transferred the resident alone to the toilet without the required mechanical device. The resident fell while they were being positioned by the PSW. The resident complained of pain, was transferred to hospital, and diagnosed with an injury.

The PSW acknowledged they did not use safe transferring techniques and the required mechanical device when assisting the resident.

Failure to use safe transferring devices and techniques by the PSW caused significant injury to the resident.

Sources: Review of the CIS report, the home's investigation notes and the resident's clinical records, and interviews with the PSW and other staff. [741670]

This order must be complied with by December 2, 2022

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.