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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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: May 3, 2023	
Inspection Number: 2023-1309-0004	
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 Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.05.15 10:55:58 -04'00'
Additional Inspector(s) Ramesh Purushothaman (741150) Inspector Nrupal Patel (000755) was present during this inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 31, 2023 and April 3, 4, 5, 17, 2023
The inspection occurred offsite on the following date(s): April 6, 11, 12, 13, 17, 18, 26, 2023

The following intakes were inspected:

- Intake: #00001845 - (Critical Incident System (CIS): 2824-000012-22) related to medication management.
- Intake: #00003364 - (CIS: 2824-000106-22) related to medication management and improper care.
- Intake: #00022795 - (CIS: 2824-000036-23) related to transferring and positioning techniques.
- Intake: #00019462 - (CIS: 2824-000014-23) related to falls management and prevention.
- Intake: #00019701 - Follow-up related to Infection Prevention and Control.

The following intakes were completed:

- Intake: #00015052 - (CIS: 2824-000128-22) related to falls management and prevention
- Intake: #00015326 - (CIS: 2824-000130-22) related to falls management and prevention
- Intake: #00022068 - (CIS: 2824-000031-23) related to transferring and positioning techniques.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1309-0003 related to FLTCA, 2021, s. 184 (3) inspected by Nicole Ranger (189)

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Residents' Rights and Choices
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that resident #005's right to have their personal health information within the meaning of the *Personal Health Information Protection Act, 2004* kept confidential.

On April 5, 2023, the inspector conducted a tour of an identified unit when they observed a documentation sheet for resident #005 left on a table in the dining room. There were no staff, residents or visitors in the vicinity. The inspector spoke with RPN #108 who observed and immediately removed the document and acknowledged that it should not have been left unattended.

Nurse Manager #102 acknowledged that the document should not have been left unattended due to privacy.

[189]

Date Remedy Implemented: April 5, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 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, related to falls interventions.

Rationale and Summary

Resident #003 was at risk of falls and required a fall intervention to mitigate risk of falls.

On an identified date, resident #003 got out of bed independently, started to ambulate and sustained a fall. The resident was transferred to the hospital the same day and was diagnosed with an injury.

PSW #104, Private companion #103 and Nurse Manager #106 confirmed that the fall intervention was not in place at the time of the fall.

Failure to ensure the care set out in the plan of care for resident #003 put the resident at risk of injury from a fall.

Sources: Review of CIS #2824-000014-23, review of resident #003's progress notes, interviews with PSW #104, private companion #103 and Nurse Manager #106.

[741150]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure resident #001 was not neglected by the licensee or staff.

Rationale and Summary

Section 7 of O. Reg 246/22 defines neglect as " the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

On an identified date, resident #001 was assessed by an external specialist and was diagnosed with a medical condition. The specialist recommended starting with a high dose medication daily with tapering to a lower dose after a few days. Physician #111 ordered to start with the high dose medication daily, with tapering every few days.

Between an identified time period, the resident displayed symptoms not at baseline.

On an identified date, the resident refused their meal and had significant decrease in arousal and less responsive. The resident became more lethargic and was assessed by RN #110. The resident became unconscious and unresponsive, and Code Blue was initiated. The resident regained consciousness and was transferred to hospital. The resident was found to have an abnormal lab result and was diagnosed with a medical condition secondary to the high dose medication.

According to evidence-based practice, the high dose medication could cause abnormal lab results after administration, and for residents with an identified medical condition, testing should be completed to monitor for the abnormal lab results.

Resident #001 had an identified medication condition. Physician #111 reported that while the resident was on the high dose medication, testing and monitoring was not ordered, leading to the abnormal laboratory result and impact to the resident's health.

Physician #111 acknowledged that the failure to monitor the resident jeopardized the resident's health which caused harm to the resident.

Sources: Resident #001's progress notes, home's investigation notes, hospital discharge summary, Medication Administration Record (MAR), physician's orders, dermatology consultation report, CIS report #2824-0000106-22, Evidence based materials (Lexicomp, retrieved April 26, 2023), interviews with RN #110, Physician #111, Medical Director, Pharmacist and Director of Care (DOC).

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WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #004 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 post fall management.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and be complied with.

Rationale and Summary:

Specifically, staff did not comply with the home's policy that directed staff to ensure the resident is not moved after a fall, prior to an assessment by registered staff.

Resident #003 had a fall on an identified date. Before the resident was assessed by the registered nurse, staff transferred the resident from floor to wheelchair.

Interview with PSW #104 and RPN #105 confirmed that nursing assessment was not completed prior to moving the resident from the floor.

Moving the resident prior to a physical assessment in accordance with the home's policy, placed the resident at risk for further injury.

Sources: Review of CIS# 2824-000014-23, review of resident #003's progress notes, LTCH's Falls Policy revised November 2019, Interviews with PSW #104, RPN #105 and Nurse Manager #106.

[741150]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee has failed to ensure that the response to a written complaint included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010.

Rationale and Summary:

The home received a compliant via electronic mail (e-mail) related to the care and services for resident #002.

Review of the licensee's response e-mail to the complaint, indicated that the response did not include the Ministry's toll-free telephone number or contact information for the patient ombudsman.

Nurse Manager #102 acknowledged that the response provided to the written complaint did not include the Ministry's toll-free telephone number or contact information for the patient ombudsman.

There was no harm or risk of harm to the resident when the Ministry's toll-free telephone number and contact information for the patient ombudsman were not provided.

Sources: Review of Critical Incident System (CIS) report #2824-000036-23, internal investigation records, Long -term Care Home's (LTCH) response email sent to the complainant, and interview with Nursing Manager #102.

[741150]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. iii.

The licensee has failed to ensure that the response provided to a person who made a complaint included if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, and a confirmation that the licensee did so.

Rationale and Summary:

The home received a compliant via electronic mail (e-mail) related to the care and services for resident #002.

Review of the licensee's response e-mail to the complaint did not specify if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act and did not confirm that it was reported to the Director.

Nurse Manager #102 acknowledged that the home's response did not include information on the home's requirement to report it to the Director.

There was no harm or risk of harm to the resident by failing to include the requirement to forward the complaint to the Director in the home's response.

Sources: Review of Critical Incident System (CIS) report #2824-000036-23, internal investigation records, Long-term Care Home's (LTCH) response email sent to the complainant, and interview with Nursing Manager #102 and Nurse Manager #106.

[741150]