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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Original Public Report

Report Issue Date: July 14, 2023

Inspection Number: 2023-1309-0005

Inspection Type:
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**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2023.07.19 11:49:39 -04'00'

Additional Inspector(s)
Maya Kuzmin (741674)
April Chan (704759)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26-30, 2023 and July 4-6, 2023

The following intake(s) were inspected:
- Intake: #00019858 - [Critical Incident (CI): 2824-000016-23] Injury of unknown cause
- Intake: #00086435 - [CI: 2824-000051-23] Injury of unknown cause
- Intake: #00088646 - [CI: 2824-000069-23] Resident to resident physical abuse

The following intake(s) were completed in this inspection: Intake: #00005386 - [CI: 2824-000009-22], Intake: #00021884 - [CI: 2824-000030-23] and Intake: #00085046 - [CI: 2824-000044-23] were related to injury of unknown cause, and Intake: #00089442 - [CI: 2824-000074-23] was related to fall with injury.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

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)
O. Reg. 246/22, s. 59 (a)

The licensee failed to ensure that steps taken to minimize the risk of altercations and potentially harmful interactions between two residents included identifying factors, based on interdisciplinary assessment or through observation that could trigger such altercations.

Rationale and Summary
(i) Resident #003 exhibited responsive behaviours, and had physical altercations with resident #002. The home implemented an intervention for a specified period.

Resident #003 approached resident #002 when an intervention was implemented by staff.

Behavioural Support Resource Team (BSRT) lead identified that resident #003 had an intervention to prevent incidents of altercations. Personal Support Worker (PSW) #116 also identified that management for resident #003's behaviours included an intervention.

Long-Term Care (LTC) Manager #114 indicated that resident #003's plan of care should be reviewed for identification of triggers of potential altercation. Resident #003's plan of care was then revised to include the specified intervention.

(ii) Resident #002 exhibited responsive behaviours and had altercations with resident #003 as mentioned above. The home implemented a plan of care that included specific interventions.

BSRT lead identified that resident #002 had altercations with resident #003. BSRT lead indicated that resident #002's plan of care should identify the risk of altercation with another resident. PSW #116 identified resident #002's specific triggers.

The resident's plan of care did not identify the trigger for resident to resident altercation. PSW #117 was not aware of any triggers and risk for resident to resident altercation.

LTC Manager #114 acknowledged that resident #002's plan of care should also be reviewed for identification of triggers of potential altercation. Resident #002's plan of care was then revised to identify a trigger for mood and behaviours.

Sources: Resident #002 and #003's clinical records, care plan, observations on June 27, 2023, interviews with BSRT lead, LTC Manager #114, and other staff.

[704759]

Date Remedy Implemented: June 30, 2023

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
On an identified date, the home submitted a CI report regarding a resident sustaining an injury.

A resident required support with transfers, including the use of specific interventions. On an identified date, the resident was transferred by a PSW without the intervention in place. The PSW did not follow the licensee's policy and resident's plan of care.

The PSW stated that the intervention was not implemented when transferring the resident. A LTC Manager stated the PSW did not follow the plan of care when transferring the resident.

Failure to use safe transferring techniques increased the risk of injury to the resident.

Sources: CI Report #2824-000016-23; resident's plan of care; home's disciplinary notes; licensee's policy

"Minimal Lift and Client/Resident Handling" revised May 23, 2023; and interviews with PSW and LTC Manager.

[740836]

WRITTEN NOTIFICATION: Required programs

NC #003 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 the falls prevention and management program to monitor a resident after a fall.

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

Specially, staff did not comply with the home's policy when assessments were not completed as required.

Rationale and Summary
The Apotex Falls Prevention policy required registered nursing staff to conduct a head injury routine if a head injury is suspected.

LTC Manager #115 indicated that assessments were to be completed over specific intervals.

On an identified date, a resident had a witnessed fall with suspected injury. The resident was reassessed by registered nursing staff.

LTC Manager #114 and #121 indicated that the resident was not reassessed at the expected frequency of assessments after a fall, and that registered nursing staff were responsible to reassess at intervals according to policy.

There was risk identified when the resident was not reassessed after a fall with injury as required by the home's falls prevention and management program.

Sources: The home's policy entitled Apotex Falls Prevention, revised November 2019, resident's clinical

records, progress note, interviews with LTC Manager #114, #115, #121 and other staff.

[704759]

WRITTEN NOTIFICATION: Falls prevention and management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee has failed to ensure that the falls prevention and management program included monitoring of a resident by a PSW.

Rationale and Summary
PSWs were to perform routine purposeful rounding (4 P's) daily on a resident to monitor resident's whereabouts and respond to their needs. A RN indicated that purposeful rounding is completed every shift by the PSW to check on the resident hourly, and includes the following criteria: positioning, toileting needs, pain and personal needs of the resident (i.e. thirst), and documentation was to be completed once per shift by the PSW.

On an identified date, a PSW completed their documentation regarding purposeful rounding, however, they admitted they did not monitor the resident using the 4 P's during their shift. A RPN indicated that POC tasks did not capture the 4 P's which may have led to purposeful rounding not being completed.

Failure to complete the monitoring of the resident by the PSW may have placed the resident at risk for falls and potential injury.

Sources: Resident's Documentation Survey Report and care plan; and interviews with PSW and other staff.

[741674]

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

The licensee has failed to comply with the strategy to implement an intervention for a resident by an assigned staff member.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written strategies to meet the needs of a resident include interventions to prevent, minimize or respond to responsive behaviours is developed and complied with.

Specially, staff did not comply with the home's policy entitled "Apotex Responsive Behaviours", revised November 3, 2022, which was included in the licensee's Responsive Behaviours Program.

Rationale and Summary
The Apotex Responsive Behaviours policy required an assigned staff member to implement an intervention. The staff member assigned was to be aware of the resident plan of care.

On an identified date, resident #003 was involved in an altercation with resident #002 resulting in an injury. At the time of the incident, an intervention was in place for resident #003.

The person who implemented the intervention during the incident was identified as an external Behavioural Support Outreach Team (BSOT) PSW and was not assigned to resident #003.

PSW #116 was assigned to the resident at the time of the incident. They indicated that the assigned PSW was expected to implement the intervention. They acknowledged that it was not the responsibility of the external BSOT PSW implementing the intervention for resident #003.

BSRT lead indicated that the external BSOT PSW was assigned to another resident and not resident #003. Both LTC Manager #114 and BSRT lead indicated that the BSOT PSW would not have access to resident #003's plan of care. They specified that the BSOT PSW was not the appropriate person to implement the intervention for resident #003.

There was risk identified when resident #003's intervention was conducted by an external PSW who was not the assigned to the resident.

Sources: CI #2824-000069-23, the home's policy Apotex Responsive Behaviours, revised November 3, 2022, resident #003's clinical records, care plan, progress note, review of surveillance video, interviews with BSRT lead, and LTC Manager #114 and other staff.

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