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: October 18, 2023

Inspection Number: 2023-1309-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Baycrest Hospital

Long Term Care Home and City: The Jewish Home for the Aged, North York

Lead Inspector	**Inspector Digital Signature**
Cindy Cao (000757)	Cindy Cao Digitally signed by Cindy Cao Date: 2023.10.18 12:09:19 -04'00'

Additional Inspector(s)
Irish Abecia (000710)
Kehinde Sangill (741670)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27-29, 2023 and October 3-6, 2023

The following intake(s) were inspected in this Critical Incident System inspection:

- Intake #00091159/CI#2824-000089-23, Intake #00091344/CI#2824-000091-23 and Intake #00094161/CI#2824-000116-23 - related to improper care
- Intake #00094345/CI#2824-000118-23 - related to falls prevention and management
- Intake #00094778/CI#2824-000122-23 - related to unknown cause of fracture
- Intake #00096275/CI#2824-000130-23 - related to medication management

The following intake(s) were inspected in this complaint inspection:

- Intake #00097161 - related to multiple concerns pertaining to the care of a resident

The following intake(s) were completed in this inspection:

- Intake #00094346/CI#2824-000119-23 and Intake #00092168/CI#2824-000101-23 - related unknown cause of fracture

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Housekeeping, Laundry and Maintenance Services
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 (1) (a)

The licensee has failed to ensure that the planned care for a resident was written in their plan of care.

Rationale and Summary
Staff reported a resident had a responsive behaviour while sitting in a wheelchair or other specific equipment.

On one occasion, the resident sustained a fall with injury during shower when they had a responsive behaviour. Personal Support Workers (PSWs) had been using a specific equipment to prevent the responsive behaviour during showers. A PSW confirmed that they had been using this intervention to ensure the resident's safety and mitigate their risk of falling. However, this intervention was not stated in the resident's plan of care.

A Nurse Manager (NM) and a Registered Practical Nurse (RPN) both acknowledged the use of a specific equipment for the resident should have been written in the resident's plan of care.

Failure to have the intervention written in the plan of care put the resident at risk of falls and injuries.

Sources: A resident's Care Plan and clinical records, interviews with a PSW, a RPN and a Nurse Manager.

[000757]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to registered staff on the administration of a medication.

Rationale and Summary
On one occasion, a resident aspirated on a medication.

The resident's diet order consisted of a specific consistency for fluids. A Registered Dietitian (RD) confirmed that all the liquids consumed by the resident including medications should be the consistency listed in the diet order. The resident was scheduled for a medication twice daily and as needed for a medical condition. One RPN confirmed that the medication administered to the resident on that occasion had a different consistency, and therefore was not the same consistency as ordered for the resident.

Three RPNs stated that they used different ways to administer the medication for the resident. A registered staff verified there were no clear directions related to administering the medication for the resident. A NM acknowledged there were inconsistencies with the administration of the medication to the resident by registered staff.

Failure to provide clear directions on the administration of the medication to the resident led to inconsistencies in the medication administration by registered staff. This increased the risk of aspiration for the resident by administrating the incorrect consistency.

Sources: A resident's clinical records; Interviews with a RD and other staff.

[000710]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure a PSW participated in the implementation of the home's Infection and Prevention Control (IPAC) program related to hand hygiene.

Rationale and Summary
On one occasion, a PSW was observed to enter a resident's room who was on precaution without performing hand hygiene. The PSW exited the room after picking up a discarded gown, dropped the gown in the laundry hamper and did not perform hand hygiene. The PSW immediately walked down the hall and entered another resident's room without performing hand hygiene.

A few minutes later, the PSW exited the resident's room wearing disposable gloves and carrying bags of soiled laundry. The PSW deposited the bags of laundry in a hamper, pushed the hamper down the hall and entered the door code to exit the unit while wearing the same disposable gloves.

The PSW acknowledged they were aware they needed to perform hand hygiene before and after environment contact, and to remove gloves and perform hand hygiene immediately after exiting a resident's room. They acknowledged that they failed to do so in this instance.

An IPAC Practitioner noted that the expectation was that staff perform hand hygiene upon entering or leaving residents' rooms. The IPAC Practitioner also acknowledged that the PSW ought to have removed the gloves and performed hand hygiene prior to exiting the room where gloves were used.

The home's hand hygiene procedure directs staff to practice hand hygiene before initial resident environment contact, and after resident environment contact including after touching any object or furniture in residents' rooms.

Staff's failure to perform hand hygiene before and after interacting with the residents' environment increased the risk of spreading infection in the home.

Sources: Observations made on one occasion; review of the home's Hand Hygiene Procedure (revised October 2019); interviews with a PSW, an IPAC practitioner and other relevant staff.

[741670]