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: April 22, 2024
Inspection Number: 2024-1309-0002
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**
Jack Shi (760)	Jia J Shi Digitally signed by Jia J Shi Date: 2024.04.25 09:52:38 -04'00'

Additional Inspector(s)
Inspector Audra Sayn-Wittgenstein (000853) attended this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 15, 16, 17, 18, 2024

The following intake(s) were inspected:

- Intake: # 00110976 - 2824-000035-24 – Related to an allegation of staff to resident incompetent care
- Intake: # 00111707 - 2824-000037-24 – Related to an allegation of staff to resident incompetent care
- Intake: # 00111422 – Related to a complaint regarding continence care and staff to resident incompetent care

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

Continence Care
Medication Management
Infection Prevention and Control

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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure a resident's plan of care was provided as it related to an intervention for the healing of their wound.

Rationale and Summary:
A complaint was received by the Ministry of Long-Term Care (MLTC) related to concerns that the resident did not receive staff's attention for a period of time. A review of the resident's care plan indicated that due to the resident's wound, they required an intervention. Interviews with the Personal Support Workers (PSW)s indicated the resident currently has a regular routine that did not align with this intervention for wound care. The Manager of Long-Term Care acknowledged that the care being provided to the resident did not align with the resident's plan of care.

Failure to ensure to provide the intervention as indicated in the resident's plan of

care may delay healing to their wounds.

Sources: A resident's care plan; Interviews with four PSWs and the Manager of Long-Term Care. [760]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee failed to ensure that a PSW was aware of the resident's plan of care prior to providing direct care for a resident.

Rationale and Summary:
A complaint and Critical Incident Systems (CIS) report were received by the MLTC indicating concerns over a PSW's care that was being provided to the resident. The resident's care plan indicated a specified intervention when it came to providing care to the resident. The PSW was unaware of this intervention and stated that it was their first time working with the resident and that they did not review the resident's care plan prior to providing care to them. The Manager of Long-Term Care stated that the PSW should have reviewed the resident's care plan prior to providing care to the resident.

Failure to review the resident's care plan prior to providing care to them may result in the resident receiving care that does not align with their assessed needs.

Sources: Interview with a PSW, the Manager of Long-Term Care and other staff; Home's investigation notes; a resident's care plan. [760]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that an Registered Practical Nurse (RPN) documented assessment of a resident during a specified period.

Rationale and Summary:
A complaint was received by the MLTC related to concerns over the resident not receiving an assessment from the staff. A review of the resident's electronic chart indicated there was missing documentation related to two scheduled assessment checks during a shift for a specified period. The RPN who worked those shifts stated that they would only document one of their assessments onto the resident's electronic chart, despite conducting the two scheduled assessments checks on their shift. The Manager of Long-Term Care stated that the RPN should document all their assessments onto the resident's electronic chart.

Failure to document all assessments onto the resident's clinical records may result in the medical team unable to review all medical assessments conducted on the resident and increase the risk of the resident not being assessed appropriately for treatments.

Sources: A resident's electronic clinical records; Interview with an RPN and the Manager of Long-Term Care. [760]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure an RPN participated in the infection prevention and control (IPAC) program, when they provided care to a resident.

Rationale and Summary:
During an observation, the RPN was observed using gloves in the care of the resident and afterwards, the RPN had proceeded to open the resident's door and exit the room without doffing their gloves. The inspector approached the RPN afterwards and the RPN stated they removed the gloves after they exited the resident's room and was in front of their treatment cart. The IPAC Practitioner stated that gloves used for resident care should be removed before the staff exited the resident's room.

Failure to adhere to the home's IPAC program may result in further spread of

infectious diseases.

Sources: Observation on the resident's care; Interview with an RPN and the IPAC Practitioner. [760]

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure an RPN administered a resident's medication in accordance to the prescriber's directions.

Rationale and Summary:
A complaint was received by the MLTC related to the RPN administering the resident's medication without the specified equipment. The resident's medical chart confirmed the use of an equipment related to a medication that the resident receives. The RPN had documented that they could not find the resident's medication equipment and therefore used their nursing judgement to administer the medication without the equipment. The RPN stated they did not inform the physician when they had decided to administer the medication without the equipment. The Manager of Long-Term Care stated that the RPN did not inform the RN supervisor or physician when they could not find the equipment and they should have taken those aforementioned measures before administering the resident's medication without the proper equipment.

Failure to follow the prescriber's instructions related to the use of an equipment may have resulted in inaccurate administration of the resident's medications.

Sources: Resident #001's medication administration records, progress notes; Interview with an RPN and the Manager of Long-Term Care. [760]