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

Original Public Report

Report Issue Date: June 24, 2024

Inspection Number: 2024-1309-0005

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**
Carole Ma (741725)	Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2024.07.05 07:51:25 -04'00'

Additional Inspector(s)
Yang Xiang (000860) was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 24, 27, 29, 30, and June 3, 4, 5, 2024
The inspection occurred offsite on the following date(s): June 13, 2024

The following Complaint intake(s) were inspected:
· Intake: #00112343 – Related to concerns of staff-to-resident abuse and neglect, potential improper care
· Intake: #00112658 – Related to concerns of staff-to-resident abuse, medication management, continence care, plan of care

The following Critical Incident (CI) intake(s) were inspected:
• Intake: #00113812 – CI #2824-000054-24 - Related to staff-to-resident abuse, improper care

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Residents' Rights and Choices

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)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary

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The licensee has failed to ensure a resident's written care plan was updated related to a care need.

Rationale and Summary
The resident's written care plan indicated they went to an on-site service for a specific care need.

A Personal Support Worker (PSW) indicated the resident had a private arrangement for someone else to provide the care need in a different location.

A Long-Term Care Manager (LTCM) confirmed the resident had a private arrangement for this care need and had not gone to the on-site service for a specified period of time. The LTCM updated the resident's care plan for this care need to indicate the resident had made a private arrangement for this care need.

Failure to ensure the resident's written care plan was updated related to this care need did not place the resident at any risk.

Sources: Resident's clinical records, Interviews with a PSW and LTCM. [741725]

Date Remedy Implemented: June 3, 2024

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)
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident

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The licensee has failed to ensure a resident's plan of care provided clear directions for a specific treatment that was provided under specific circumstances, a clear target range for a vital sign under specific circumstances, and clear interventions for when a resident performed a specific action.

Rationale and Summary
1) The resident required administration of a specific treatment under specific circumstances and for their specific vital sign under specific circumstances to be kept within a target range.

In three different areas of the resident's plan of care, directions for administering the specific treatment under specific circumstances were inconsistent.

In two different areas of the resident's plan of care, the target range for the specific vital sign under specific circumstances was also inconsistent.

A PSW indicated they followed one area of the resident plan of care for administering the specific treatment and observed a range for the specific vital sign under specific circumstances.

A LTCM acknowledged the inconsistencies in the resident's plan of care on directions for administering the specific treatment and the target range for the specific vital sign under specific circumstances.

Failure to ensure the resident's plan of care was consistent for the specific treatment and the specific vital sign under specific circumstances placed the resident at potential risk for an exacerbation of their chronic health condition.

Sources: Resident's clinical records, Interviews with a PSW and LTCM. [741725]

2) Within a defined period of time, a resident performed a specific action multiple times indicating there was an emergency, when there was not an emergency. On multiple occasions, the resident performed this action multiple times and co-residents who were distrubed during their sleep complained.

The resident's clinical records indicated they performed this action for various reasons.

In a specific quarterly assessment, the resident's actions were identified as socially inappropriate/disruptive. Non-pharmacological interventions were provided for how staff should respond.

Interventions specific to the resident performing this action indicating there was an emergency, when there was not an emergency were not included in the resident's written care plan, which a PSW indicated they accessed to learn of the resident's care needs. The PSW indicated when the resident performed this action, a Code White would be called.

A LTCM acknowledged that there were no interventions provided in the resident's written care plan specifically for when they performed this action indicating there was an emergency when there was not an emergency.

Failing to ensure interventions were included in the resident's written care plan when they performed this action indicating there was an emergency and there was no emergency resulted in the home potentially responding in an escalated manner.

Sources: Resident's clinical records, Interviews with a PSW and LTCM. [741725]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. 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

The licensee has failed to ensure a resident was provided with the contact information for the Ministry of Long-Term Care (MLTC) and the patient ombudsman after making a verbal complaint related to the care they received in the home.

Rationale and Summary
A resident made a verbal complaint to an after-hours supervisor related to the care they received in the home. The home submitted a Critical Incident System (CIS) report the next day.

The resident indicated they were not provided with contact information to the MLTC and patient ombudsman for this complaint.

The CIS report and the home's investigation notes did not indicate the resident was provided with contact information to the MLTC and the patient ombudsman.

A LTCM indicated the resident had previously been provided with contact

information to the MLTC and was not provided with contact information to the patient ombudsman because the complaint was verbal and not written.

Failure to provide the resident with contact information to the MLTC and patient ombudsman for this verbal complaint resulted in a lack on transparency of how the resident may seek an independent review of their concerns.

Sources: CIS report, home's investigation notes, Interviews with the resident and LTCM. [741725]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. B.
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief

The licensee has failed to ensure a resident was provided with an explanation with reasons for why the home believed their complaint was unfounded.

Rationale and Summary
A resident made a verbal complaint to an after-hours supervisor related to the care they received in the home. The home submitted a CIS report the next day.

The resident indicated they were not provided with any follow up from this complaint.

The CIS report and the home's investigation notes indicated an investigation into the complaint was conducted. There was, however, no indication that the home provided an explanation to the resident as to why the complaint was unfounded.

A LTCM indicated when they had attempted to verbally inform the resident of the home's investigation into the complaint, the resident began raising their voice. The LTCM indicated there was no other way to have let the resident know of the investigation and its outcome, but also noted sometimes a specific staff member spoke with the resident if they were triggered by the LTCM, and that the resident had email access.

Failure to ensure the resident was provided with an explanation as to why their complaint was unfounded resulted in a lack of transparency in the home's complaints process.

Sources: CIS report, home's investigation notes, Interviews with the resident and LTCM. [741725]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (e)
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response

The licensee has failed to ensure a documented record was kept that included every date a response was provided by the home to a resident with respect to their verbal complaint, and a description of the response.

Rationale and Summary
A resident made a verbal complaint to an after-hours supervisor related to the care they received in the home. The home submitted a CIS report the next day.

The resident indicated they were not provided with any follow up from this complaint.

A LTCM acknowledged the resident made a complaint that included longstanding issues, which could not be resolved. The LTCM also acknowledged they did not keep a documented record of this complaint in the home's 2024 Complaints Binder as it was followed up in a CIS report.

The CIS report indicated the unit manager and care team would meet with the resident to discuss strategies but a date was not provided for when this occurred. The home's investigation notes only indicated an investigation into the complaint was conducted but there was no information on a response provided to the resident.

Failure to ensure a documented record of every date on which a response was provided by the home to the resident, and a description of the response, resulted in a loss of transparency in the home's complaints process.

Sources: CIS report, home's investigation notes, home's 2024 Complaints Binder, Interviews with the resident and LTCM. [741725]

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WRITTEN NOTIFICATION: SAFE STORAGE OF DRUGS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked

The licensee has failed to ensure that the door to the medication room on a specific unit was secured and locked.

Rationale and Summary
On a specific day, the medication room door on a specific unit was observed to have been left opened and unattended. The medication room opened directly into the hallway where a resident who was ambulatory was seated.

A Registered Practical Nurse (RPN) indicated they had kept the medication door open as the lock was difficult to open with the key, and the access card was not working due to a Code Grey. They indicated they had left the medication room door opened and unattended as they went to find another nurse for assistance.

The RPN showed the Inspector that inside the medication room there was a government supply of medications in a locked cabinet, insulin in the refrigerator, drug disposal bins, including one that read "cytotoxic" on the lid, and a full sharps disposal container.

A LTCM confirmed that leaving the medication room door unsecured and unattended did not meet the expectations of the home.

Failing to ensure the medication room was secured and locked placed residents at risk for a medication incident.

Sources: Observation, Interviews with an RPN and LTCM. [741725]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (3) (b) (ii) (A)
s. 140 (3) Subject to subsections (4) and (6), the licensee shall ensure that no person administers a drug to a resident in the home unless,
(b) where the administration does not involve the performance of a controlled act under subsection 27 (2) of the Regulated Health Professions Act, 1991, the person is,
(ii) a personal support worker who has received training in the administration of drugs in accordance with written policies and protocols developed under subsection 123 (2), who, in the reasonable opinion of the licensee, has the appropriate skills, knowledge and experience to administer drugs in a long-term care home, who has been assigned to perform the administration by a member of the registered nursing staff of the long-term care home and is under the supervision of that member in accordance with any practice standards and guidelines issued by the College of Nurses of Ontario, and who,
(A) meets the requirements set out in subsection 52 (1) or who is described in subsection 52 (3)

The licensee has failed to ensure PSWs received training in administration of a treatment for a resident.

Rationale and Summary

A resident required a specific treatment administration. Their plan of care provided details for this treatment administration under specific circumstances, and indicated the task could be performed by registered staff and PSWs that had this activity delegated or taught to them.

A PSW indicated they provided this treatment administration under specific circumstances. They also indicated that they received no training to perform this task.

A RPN indicated sometimes they would be called in to provide this treatment administration under specific circumstances to the resident, and that sometimes PSWs would provide it themselves despite the RPN advising them not to perform this task. The RPN was not aware of any training PSWs received for this treatment administration.

The home did not have a policy related to PSWs administering this treatment to residents.

Failure to ensure PSWs were trained in this treatment administration for this resident placed the resident at risk for a treatment-related incident and a worsening in their chronic health condition.

Sources: Resident's clinical records, Interviews with a PSW and RPN. [741725]