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

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Original Public Report

Report Issue Date: September 27, 2024

Inspection Number: 2024-1309-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Baycrest Hospital

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 21- 23, 26 – 27, 29 - 30, 2024 and September 3 – 6, 9, 2024

The following intake(s) were inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00117131 – (CIS: 2824-000067-24) – related to physical abuse resulting in bruising
- Intake: #00117548 – (CIS: 2824-000070-24) – related to improper care or physical abuse in relation to unknown cause of bruising
- Intakes: #00117616 – (CIS: 2824-000072-24) and #00124324 – (CIS: 2824-000128-24)– related to an unwitnessed fall resulting in injury
- Intake: #00119111 – (CIS: 2824-000081-24) – related to improper care/neglect of resident
- Intake: #00120253 – (CIS: 2824-000090-24) – related to neglect of resident related to repositioning, continence care, pain management
- Intake: #00124519 – (CIS: 2824-000129-24 – related to Verbal/physical abuse

The following intakes were inspected in the Complaint Inspection:

- Intake: #00118101 – related to refusing to give bath, plan of care and communication
- Intake: #00118340 – related to emotional abuse, neglect, plan of care, bathing
- Intake: #00123004 – related to applicant bed refusal

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

- Intake: #00121315 – (CIS: 2824-000102-24) – COVID-19 outbreak

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Pain Management
Falls Prevention and Management
Admission, Absences and Discharge

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 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure that the resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
The resident's SDM had submitted a complaint to the home related to concerns that they were not notified by the nursing staff members when the resident's private caregiver had noted an altered skin integrity. The home's policy titled, "Apotex Skin & Wound Care program", dated April 2024 indicates that the nurse would notify the resident's SDM of any skin integrity issues. The home's investigation noted that the Registered Practical Nurse (RPN) had stated they did not notify the resident's SDM on the same day they were informed of the resident's altered skin integrity. Manager of Long-Term Care stated that the expectations would be for the RPN to notify the resident's SDM on the same shift the altered skin integrity was found and that if they were unable to notify the SDM on their shift, to endorse this to the next shift to follow up.

Failure to ensure that the resident's SDM receives timely communication about a resident's health status may result in the SDM not having the opportunity to fully participate in the development and implementation of the resident's plan of care.

Sources: Home's Apotex Skin & Wound Care policy, dated April 2024; Home's

investigation notes; Interview with RPN, Manager of Long-Term Care and other staff.

WRITTEN NOTIFICATION: Authorization for admission to a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (c)
Authorization for admission to a home
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

The licensee has failed to comply with FLTCA s. 51 (7) whereby the licensee refused an applicant's admission to the home based on reasons that were not permitted in the legislation.

Specifically, the licensee withheld the approval for the admission citing the reasons as: circumstances existed which were provided for in the regulations as being a ground for withholding approval.

Rationale and summary:
The Ministry of Long-Term Care (MLTC) received a complaint related to withholding an applicant's admission. The placement coordinator did not provide information to the home related to a change in the applicant's condition due to the fact that Manager of Long-Term Care stated that this applicant was not accepted into the facility at the time of the inspection and was previously on a waitlist. The letter

provided to the applicant indicating the withholding of admission to the home had cited Ontario Regulations 246/22 s. 59, which does not pertain to the circumstances that exists in the regulations as being a ground for withholding approval.

When the home withheld the applicant's approval for admission without the appropriate grounds, they were not able to transition to the LTCH of their choice.

Sources: Applicant's letter of withholding admission to the home; Interview with Manager of Long-Term Care.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
i) On a particular day, the door leading into a non-residential room on a resident's home area was left ajar and unsupervised.

Interview with the housekeeping staff acknowledged that the door to the non-

residential room should be locked at all times.

There was a safety risk to residents when the door to the non-residential room was kept open while unsupervised.

Sources: Observations on a particular day; interviews with housekeeping staff and Environmental Service Manager (ESM).

Rationale and Summary
ii) A Personal Support Worker (PSW) was observed entering and exited a non-residential room on the resident home area without ensuring the door was closed and locked. The door again was left ajar.

The PSW acknowledged that they failed to ensure that the door to a non-residential room was closed and locked behind them.

The ESM acknowledged that the door to the non-residential room must be kept locked at all times when not in use.

Failure to ensure that doors leading to non-residential room was kept closed and locked when not being supervised poses a potential safety risk to residents.

Sources: Observations on a particular day; interviews with PSW and ESM.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)
Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee has failed to ensure that procedures were implemented for cleaning multiple surfaces.

Rationale and Summary
During an observation on the resident's home area, a housekeeping staff was observed cleaning multiple surfaces with the same micro fiber cloth.

The Environmental Services Manual directs staff to use a clean cloth for each procedure and that cloths should be changed frequently.

The Housekeeping staff acknowledged that they used the same cloth to clean multiple surfaces.

The ESM acknowledged that the housekeeping staff should have changed their cloth between cleaning different surfaces.

Staff failure to frequently change their cleaning cloth in between multiple surfaces may increase the risk of spreading microorganisms.

Sources: Observation of housekeeping staff cleaning practice, home's policy "Aramark Senior Living: Environmental Services Manual," revised June 30, 2021, interviews with housekeeping staff, Infection Prevention and Control Lead (IPAC)

and ESM.

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (c)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(c) removal and safe disposal of dry and wet garbage; and

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures were implemented for removal and safe disposal of dry and wet garbage.

Rationale and Summary
On a particular day, the housekeeping staff was observed removing garbage inappropriately and then disposing them into their cleaning cart.

The housekeeping staff acknowledged that they were required to remove the garbage using the garbage waste liner but did not.

The home's Environmental Services Manual, revised June 30, 2021, directs staff to remove the waste liner from the receptacles, never compact waste with hands, seal the waste liner and always hold it away from your body to avoid any injury.

Failure to follow the home's policy for safely disposing of garbage poses the risk of staff injury and increase the spread microorganisms.

Sources: Observation of the housekeeping staff cleaning practices, home's policy "Aramark Senior Living: Environmental Services Manual," revised June 30, 2021 interviews with housekeeping staff, IPAC Lead and ESM.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was complied with.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 10.2 (c) states that licensee shall ensure that the hand hygiene program for residents has a resident centered approach with options for residents, while ensuring that hand hygiene is being adhered to. The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks. Specifically, the licensee has failed to provide hand hygiene to all residents prior to and after eating.

Rationale and Summary
i) During lunch meal service observation on the resident home area, residents were not offered or assisted with hand hygiene.

The PSW advised that they were responsible for assisting the residents with hand hygiene prior to the meal service and acknowledged they had not offered or assisted any residents with hand hygiene.

Failure to ensure that residents were supported with performing hand hygiene prior to the meal service could place residents at increased risk for infection transmission.

Sources: Observations of lunch meal service; IPAC Standard (revised Sept 2023); interview with PSW.

In accordance with the IPAC Standard for Long-Term Care Homes issued by the director, revised September 2023, section 9.1 states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program and at minimum Routine practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene; before initial resident/resident environment contact and after resident/resident environment contact. Specifically, the licensee has failed to ensure that staff comply with the hand hygiene program prior to assisting residents at meal service.

Rationale and Summary
ii) During a meal service observation on a resident's home area, a PSW was observed touching/fixing their hair and had their hands in their uniform pocket. The PSW failed to performed hand hygiene prior to serving residents their beverages.

The PSW acknowledged that they did not performed hand hygiene prior to serving beverages to the residents.

Failure for staff to perform hand hygiene before initial resident contact poses an

increased risk for infection transmission.

Sources: Observation of a PSW during meal service; IPAC Standard (revised Sept 2023); interview with PSW.

WRITTEN NOTIFICATION: CMOH and MOH

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives or recommendations issued by the Chief Medical Officer of Health (CMOH) was followed by the home, in relation to alcohol-based hand rub (ABHR). Specifically, ABHR must not be expired as required by 3.1 IPAC Measures under Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Summary and Rationale
i) On a particular day, the ABHR placed at the entrance of the dining room on a resident home area was observed to have expired.

Interview with the RPN advised that the ABHR was being used by staff to assist residents with hand hygiene as they entered the dining room. They were unaware the ABHR had expired until it was brought to their attention by the inspector.

Failure to ensure that the ABHR was not expired may have increased the risk of transmission of infectious microorganisms.

Sources: Inspector observations; and interview with the RPN and IPAC Lead.

Summary and Rationale
ii) The ABHR located on the medication cart on the resident resident home area was observed to have expired.

Interview with the RPN confirmed that the ABHR located on the medication cart was expired.

Failure to ensure that the ABHR was not expired may have increased the risk of transmission of infectious microorganisms.

Sources: Inspector observations; and interviews with the RPN and IPAC Lead.