Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 9, 2021	2021_926267_0006	016587-21	Critical Incident System

Licensee/Titulaire de permis

Baywoods Place Operating Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

BayWoods Place
330 Main Street East Hamilton ON L8N 3T9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOBBY JAMES (694267), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 22, 23, 24, 25, 26 (off-site), 29, 30, December 07 (off-site), 2021.

The following intake was completed for the Critical Incident System (CIS) Inspection:
Log #016587-21 (CIS #2581-000007-21) was related to fall with injury.

During the course of the inspection, the inspector(s) spoke with the home's Administrator/Executive Director (ED), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) lead, Physiotherapist (PT), Pharmacist, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), housekeeping staff, and residents.

During the course of the inspection, the inspector(s) toured the home, observed resident care and hand hygiene during meal and snack service, reviewed relevant notes, policies and procedures related to the CIS.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's plan of care included clear directions to staff who provided direct care to the resident.

A resident's care plan was initiated for the resident to use a specialized device for locomotion. The resident required assistance to use this device to visit another facility three times per week but they did not receive this assistance regularly. The resident felt that using their specialized device on their own was "very limited and very exhausting."

The PT stated that the resident required a certain level of assistance for their specialized device and could not mobilize very far on their own.

The ADOC confirmed that as per the last Minimum Data Set (MDS) assessment, the resident required the same level of assistance as noted by the PT but the plan of care did not provide staff with clear directions regarding the level of assistance required.

Failing to provide clear direction to the staff on the level of assistance required for the specialized device had caused the resident to experience discomfort and fatigue and was at a risk of injury.

2. The licensee has failed to ensure that a resident's plan of care was reviewed and

revised at any other time when the resident's care needs changed.

In July 2021, the plan of care was initiated for an assistive device for a resident.

In August 2021, the PT assessed the resident and documented that the resident's assistive device had been changed. The plan of care was not revised.

In September 2021, the PT removed the assistive device from the resident's home area and stored it in the PT's office. The plan of care was not revised.

In November 2021, the resident confirmed that their mode of locomotion had changed.

The ADOC agreed that the plan of care was not updated according to resident's present care needs.

By not updating the plan of care, the resident was at a risk of receiving an inconsistent level of care provided by the staff.

Sources: Observation of the resident's room, review of resident's electronic health records, care plan July 2021 version, interview with the resident and interview with the PT and the ADOC.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's care plan provide clear direction to the staff and others who provided direct care to the resident and that the plan of care is reviewed and revised as the resident's care needs change and or when the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the pain policies and procedures included in the Pain Assessment and Management System were complied with, for residents #001 and #008.

In accordance with O. Reg. 79/10, s. 48 (4) , and in reference to O. Reg. 79/10, s. 52 (1) (4) and 52 (2), the licensee was required to monitor residents responses to and effectiveness of pain management strategies including assessment of the resident using a clinically appropriate assessment instrument specifically designed for this purpose when initial pain interventions are not effective.

Specifically, staff did not comply with the licensee's policy for 'Pain Assessment and Symptom Management Program', effective August 2016, which stated: "All Residents are assessed using a standardized, evidence-informed clinical tool that is appropriate for Resident's cognitive level. The effectiveness of pain interventions are monitored, and Resident outcomes are evaluated and documented".

A. On identified dates in September, October and November 2021, an as needed (PRN) pain medication was administered for resident #001 but the pain monitoring was not completed by staff by using the home's assessment tool.

In September 2021, the resident complained of pain, medication was administered but no pain assessment was done using the home's pain assessment tool.

In October 2021, the resident returned from the hospital but no pain assessment was done using the home's pain assessment tool.

In November 2021, the resident returned from the hospital, but no pain assessment was done using the home's pain assessment tool.

The RN confirmed that the pain monitoring and pain assessment was not completed for resident #001.

For the purpose of expanding scope for non-compliance identified with resident #001, resident #008 was reviewed.

B. On an identified date in November, as needed (PRN) pain medication was administered for resident #008 but the pain monitoring was not completed by staff by using one of the home's assessment tool.

In November, resident #008 complained of a new area of pain, medication was administered but no pain assessment was completed using the home's clinical assessment tool. The assessments done on Point Click Care (PCC) over a two-month period confirmed that there was no pain assessment initiated.

The ADOC confirmed that staff did not comply with the licensee's pain policy which directed registered staff to initiate a pain assessment when a new or worsened pain was noted for resident #008.

As a result of not conducting a pain assessment and not monitoring the effectiveness of the pain treatment that residents #001 and #008 received, they remained at a risk of not receiving proper treatment for pain relief.

Sources: Observation of the resident #001, review of medication administration record of resident #001 and other pain related documentation, review of medication administration record of resident #008 and other pain related documentation, pain assessment policy, Index # CARE 8-010.01, Index #CARE8-O10.02, Index #CARE8-P10, summary of assessment section on PCC, interview with the resident #001, interview with RN and the ADOC.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act and Regulation require the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

A. The Long-Term Care Home (LTCH) Inspectors noted that four rooms in one resident home area had signage for contact/droplet precautions but eyewear was not readily available in the Personal Protective Equipment (PPE) hand bag. A staff on the unit could not find the eye wear in the PPE hand bag or in the PPE bin outside the door.

The IPAC lead acknowledged that the eyewear was not readily available at the door along with the other PPE and agreed to update the PPE bags with eye protection equipment.

A review of the home's COVID-19 manual stated that "Prepare PPE carts/caddies/supplies for each room including: Closed and separate receptacles for masks, N95, gloves, gowns, and eye protection".

B) The LTCH Inspectors observed that a PSW was in the room of a resident delivering snacks who required contact/droplet precautions. The staff were observed entering the resident's room and was less than two meters away from the resident but did not use eye protection as a part of the proper PPE.

The PSW was unsure about the use of eyewear during snack pass. The PSW confirmed that they were less than two meters away from the resident when delivering snacks.

The lPAC lead confirmed that staff must wear eyewear within two meters of the resident.

By not having immediate access to the PPE and not wearing appropriate PPE for contact/droplet precautions, the residents were at an increased risk of acquiring and or transmission of infection.

Sources: Observation of the resident home areas, review of Revera COVID-19 playbook manual V.4.2.0, review of Infection Control policy (IPAC) Index # IPC2-010-07, interview with the IPAC lead and staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff participate in the implementation of the IPAC program, to be implemented voluntarily.

Issued on this 10th day of December, 2021

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.