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: May 31, 2024

Inspection Number: 2024-1309-0004

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: 2024.05.31 12:08:39 -04'00'

Additional Inspector(s)
Britney Bartley (732787)
Carole Ma (741725)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 9, 10, 13, 14, 15, 16, 2024.
The inspection occurred offsite on the following dates: May 17, 21, 2024.

The following Critical Incident System (CIS) intakes were inspected:

- Intakes# 00103580, CIS #2824-000193-23, #00106301, CIS #2824-000012-24, and #00107828, CIS #2824-000024-24 - related to allegation of improper resident care
- Intakes# 00107189, CIS# 2824-000016-24, 00107507, CIS# 2824-000019-24, and #00107605, CIS #2824-000021-24 - related to disease outbreak

- Intake: #00111374 - CIS# 2824-000036-24 - related to an allegation of staff to resident abuse
- Intake: #00113315 - CIS# 2824-000047-24 - related to a fall

The following complaint intake was inspected:

- Intake: #00114430 - related to medication administration practices

The following intakes were completed in this inspection:

- Intake #00112965, CIS#2824-000042-24 and #00108667, CIS #2824-000029-24 - related to an injury with a significant change in condition.

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

Continence Care
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee failed to ensure a Registered Practical Nurse (RPN) kept residents' personal health information (PHI) in a confidential manner.

Rationale and Summary
A complaint was received related to a concern from a resident's substitute decision maker (SDM) regarding an allegation that the resident did not get their medications from the RPN. During the home's investigation, another RPN who was shadowing this RPN that day indicated they had noticed them discarding some residents' medication strips directly in the garbage bin. The home's policy stated to discard used strip packaging in accordance to procedures to ensure compliance with Personal Health Information Protection Act. The other RPN stated that this RPN should not have discarded the residents' medication strips in the garbage bin because there was residents' PHI on the strips. The On-Call Manager who was called to attend the situation stated they had seen some residents' medication pouches in the garbage bin that day. A Registered Nurse (RN) stated it would not be appropriate to discard the medication strips in the garbage bin. The Manager of Long-Term Care stated that the medications strips should have been discarded in specified location in the medication room and not in the garbage bin and confirmed that the RPN did not protect the residents' PHI.

Failure to ensure that residents' PHI was protected may result in a breach of their PHI.

Sources: Investigation notes related to this incident; Interview with an RPN, the Manager of Long-Term Care, an On-Call Manager and an RN; Policy titled, "Medisystem Medication Management Manual prepared for Apotex Centre, Jewish Home for the Aged", dated January 2024. [760]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital

The licensee has failed to ensure a resident who was at risk for altered skin integrity received a head-to-toe skin assessment upon return from hospital.

Rationale and Summary
An RPN documented that a resident had a fall that resulted in injuries and required a transfer to the hospital on the following day. The resident returned from the hospital on the same day.

An RPN confirmed that the Head-to-Toe Skin Assessment form should have been completed for the resident upon return from hospital and that it was not.

Failing to ensure that the resident received a skin assessment upon return from hospital placed them at risk for a potential unidentified change of their wounds related to the hospital transfer.

Sources: A resident's clinical records, home's "Apotex Skin and Wound Care Program Policy", last revised/reviewed November 3, 2022, Interview with an RPN. [741725]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure a resident's injuries were assessed using the home's skin and wound assessment instrument.

Rationale and Summary
An RPN and RN documented that a resident had a fall that resulted in various skin injuries.

The home's skin and wound care policy indicated a nurse would conduct and document an initial Skin and Wound Care Assessment for a resident exhibiting altered skin integrity.

An RPN confirmed that the Skin and Wound Care Assessment form should have

been completed for the resident and that it was not.

Failing to ensure the Skin and Wound Care Assessment form was completed resulted in inconsistent documentation and a missed opportunity in establishing a clear baseline of the resident's injuries resulting from the fall.

Sources: A resident's clinical records, home's "Apotex Skin and Wound Care Program Policy", last revised/reviewed November 3, 2022, Interview with an RPN. [741725]

WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)
Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee failed to ensure that the Director was immediately informed of a disease outbreak.

Rationale and Summary
The IPAC (Infection Prevention and Control) Manager was notified by Toronto Public Health to declare an outbreak on a unit. The IPAC Manager informed the Director by completing a Critical Incident System (CIS) report on the following day. The licensee was required to immediately report the disease outbreak using the Ministry's after-hours emergency line.

The IPAC Manager acknowledged the home should have immediately informed the Director of the outbreak.

Failure to immediately report the outbreak through the after-hours emergency line poses the risk of the Director not able to follow-up.

Sources: CIS report: #2824-000021-24 and interview with the IPAC Manager. [732787]

WRITTEN NOTIFICATION: Medication Management System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the system to ensure accurate administration of two residents' drugs.

In accordance with O. Reg 246/22 s. 11 (1) (b), written policies and protocols were developed for the medication management system to ensure the accurate administration of all drugs used in the home and was required to be complied with.

Specifically, the licensee did not comply with the medication management policy titled, "Medisystem Medication Management Manual prepared for Apotex Centre,

Jewish Home for the Aged", dated January 2024, which required staff to document medications at the time of administration.

Rationale and Summary
A complaint was received related to a concern from a resident's SDM regarding an allegation that the resident did not get their medications from an RPN. The home's medication administration policy stated that nurses were to initial on the resident's electronic medication administration record (eMAR) during the process of medication administration. A review of the eMAR documentation and the home's surveillance footage demonstrated that the RPN was not administering medications at the time of their eMAR documentation.

The Manager of Long-Term Care stated that medications were to be documented on the residents' eMAR at the time of administration based on the home's policies and procedures. They confirmed that the actions of the RPN did not align with the home's medication management policy.

Failure to ensure the documentation of medication at the time of administration may result in medication errors.

Sources: Surveillance footage from the hallway of a resident unit; Two resident's eMAR; Home's investigation notes; Policy titled, "Medisystem Medication Management Manual prepared for Apotex Centre, Jewish Home for the Aged", dated January 2024. [760]

WRITTEN NOTIFICATION: Administration of Drugs

NC #006 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 medications in accordance to the prescriber's instructions.

Rationale and Summary
A complaint was received related to a concern from the resident's SDM regarding an allegation that the resident did not get their medications from the RPN.

The surveillance footage indicated that the RPN had not provided the resident's medication during their shift. However, the RPN had documented on the resident's eMAR that the medications were administered and also had claimed that they did. The surveillance footage also showed that the RPN was in the nursing office while they had documented that the resident's medications were administered in the resident's eMAR. A Personal Support Worker (PSW) stated they were observing the resident from the start of the RPN's shift and confirmed they had not witnessed the RPN giving the resident their medications. The Manager of Long-Term Care stated that based on the surveillance footage reviewed and documentation on the eMAR, they believed the resident did not received their medications.

Failure to ensure that the resident received their medications may lead to a decreased quality of life for the resident.

Sources: Surveillance footage from the resident's room and a resident unit; Interview with the Manager of Long-Term Care, a PSW and other staff; the resident's eMAR. [760]