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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Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: February 22, 2024
Original Report Issue Date: February 5, 2024
Inspection Number: 2024-1309-0001 (A2)
Inspection Type: Critical Incident
Licensee: Baycrest Hospital
Long Term Care Home and City: The Jewish Home for the Aged, North York

AMENDED INSPECTION SUMMARY

This report has been amended to:
This inspection report has been amended to: Non-compliance Remedied related to NC#001 FLTCA, 2021, s. 6 (1) (a).

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 18, 19, 22-26 and 29, 2024

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake #00098052/C I#2824-000154-23; Intake #00101729/CI #2824-000179-23; #00102779/CI#2824-000187-23 was related to improper/incompetent treatment that resulted in harm to a resident.
- Intake #00101028/CI #2824-000172-23; #00104598/CI #2824-000204-23; Intake: #00104871/CI #2824-000209-23; #00105145/CI #2824-000211-23 was related to a fall prevention and management

- Intake #00101665/CI #2824-000178-23; #00101664/CI #2824-000177-23; #00102718/CI #2824-000185-23; #00104372/CI #2824-000199-23; #00104463/CI #2824-000200-23; #00105384/CI#2824-000212-23 was related to an outbreak.
- Intake #00103442/CI #2824-000191-23 was related to unknown cause of injury.
- Intake: #00104683/CI #2824-000207-23 was related to neglect of a resident by a staff.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

AMENDED 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 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the planned care for resident #005 included fall interventions as part of their fall management intervention.

Rationale and Summary
Registered Practical Nurse (RPN) #113 stated that a resident required two fall interventions since they fell.

A month later, the resident's care plan did not note the use of two fall interventions.

The registered staff acknowledged the use of two fall interventions were not written in the resident's care plan. The registered staff and Falls Lead #116 both stated that the resident's care plan should have included the two fall interventions.

After being notified, the registered staff updated the resident's care plan to include the two fall interventions.

There was low risk to the resident when their written plan of care did not include use of two fall interventions.

Sources: Resident's clinical records; and interview with registered staff and Falls Lead #116.
[000711]

Date Remedy Implemented: January 23, 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 (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 has failed to ensure that the care set out in a resident's plan of care related to continence was provided to the resident.

Rationale and Summary

A resident's care plan under continence care directed staff to follow specific interventions. A direct care staff documented in their statement during the home's investigation that they did not follow the resident's care plan during the provision of continence care on a specified date.

The direct care staff acknowledged they did not provide continence care to the resident as specified in their plan of care. Nurse Manager (NM) #129 stated that direct care staff were responsible to follow the intervention in the resident's plan of care.

There was an increased risk of improper care to the resident when their care plan was not followed by direct care staff during the provision of continence care.

Sources: Resident's plan of care; interview with direct care staff and NM #129.

[741674]

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 has failed to ensure that the provision of the care set out in the resident's plan of care related to meal intake was documented.

Rationale and Summary

There was no documentation of the provision of care for resident #003 on November 12, 2023. RPN #128 documented that the resident consumed 100 percent (%) of their meal and half of a cup of water.

A direct care staff acknowledged they did not document the provision of care for the resident on a specified date because they left work early. NM # 129 stated that the expectation of direct care staff was to complete their Point of Care (POC) documentation related to provision of care by end of their shift.

Failure to document the provision of care posses a risk to the resident.

Sources: Resident's Documentation Survey Report and Progress Notes; Interview with direct care staff and NM #129.

[741674]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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; or

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when their continence care needs changed.

Rationale and Summary
A resident required assistance with continence care. A resident's family member reported to NM #129 that when the resident required toileting or changing they would display an identified behaviour.

Resident's caregiver stated that they had communicated about the resident's continence care needs to direct care staff multiple times. Two direct care staff, and a registered nurse, all acknowledged that they were aware the resident would require continence care when they display an identified behaviour.

Registered staff and NM #129 both acknowledged this intervention was not included in the resident's care plan prior to the concern being brought forward by the resident's family member. The registered staff acknowledged that the resident's care plan should had been revised and updated when staff became aware of the intervention. NM #129 confirmed that nursing staff were responsible for updating the resident's plan of care when there were changes in their care needs.

Failure to revise the resident's continence care plan may potentially delay staff response to their needs and put them at risk for impaired skin integrity.

Sources: Resident's clinical records, interviews with resident's caregiver, direct care staff and registered nurse and NM #129.

[000757]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when masking requirements were not followed by Housekeeper#105.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023; all staff, students, volunteers, and support workers wear a medical mask in all resident areas indoors.

Rationale and Summary

Housekeeper #105 was observed cleaning inside a resident's room without wearing a face mask. There were no individuals observed within one meter distance to the

housekeeper.

IPAC Lead #117 confirmed that all staff must wear a face mask at all times inside the resident home areas.

Staff's failure to don a face mask inside resident home areas increased the risk of infection transmission to residents, other staff and visitors.

Sources: Observation on a specified date; interviews with Housekeeper #105 and the IPAC Lead #117; and Minister's Directive: COVID-19 response measure for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario.
[000711]

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 a standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented. Specifically, additional requirement 9.1 (b) of the "IPAC Standard for Long Term Care Homes April 2022 revised September 2023" directs homes to ensure proper hand hygiene, including but not limited to, the four moments hand hygiene after resident or resident

environment contact.

A direct care staff did not perform hand hygiene after coming into contact with a resident's environment.

Rationale and Summary:

A direct care staff was observed exiting a resident's room with equipment. They proceeded to remove their gloves, did not perform hand hygiene and then assisted to move another resident in a wheelchair..

The home's policy titled "Handy Hygiene Procedure" directed staff to perform hand hygiene at the four moments of hand hygiene, particularly, after resident environment/resident contact.

The direct care staff acknowledged that they did not perform hand hygiene upon exiting the resident's room after they removed their gloves. A registered staff and IPAC Practitioner #117 both stated that staff were expected to follow the policy and should have performed hand hygiene after removal of gloves.

There was an increased risk of infection transmission when the direct care staff did not perform hand hygiene upon exiting the resident's room.

Sources: Observations on a specified date; Hand Hygiene Policy (revised October 19, 2023); Interviews with direct care staff and registered nurse and IPAC Practitioner #117.

[741674]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (a)
Infection prevention and control program
s. 102 (4) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;

The licensee has failed to ensure a caregiver followed the masking requirement in resident care areas of the home.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have an infection and prevention control program and must be complied with. Specifically, two caregivers did not comply with the Baycrest Masking Policy (date revised/reviewed: December 1, 2023) to wear a face mask when in resident care areas where an interaction with a resident could occur on a specified date.

Rationale and Summary

(i) Inspector observed private caregiver #108 in the hallway without a mask and covering their face with their sweater while talking on their cellphone.

Private caregiver #108 acknowledged they were not wearing a mask when they were sitting in the hallway and speaking on their cellphone. IPAC Practitioner #117 stated that the expectation was for caregivers to wear a mask outside of the resident's room in the hallways due to potential risk of resident interaction.

Failure to follow the home's masking policy placed residents at increased risk of potential exposure to infectious respiratory droplets.

Sources: Observations on a specified date; Baycrest Masking Policy (revised December 1, 2023); Interviews with Private Caregiver #108 and IPAC Practitioner #117.

[741674]

(ii) Private caregiver #118 was observed with a face mask under their chin in the hallway.

The private caregiver acknowledged that they should have worn a face mask when in the hallway. The IPAC Practitioner #117 stated that a face mask should be worn to cover the nose and mouth. The IPAC practitioner acknowledged caregivers were required to wear face masks in resident care areas which included the hallway as per the home's masking policy.

Failure to ensure a caregiver appropriately don a face mask in resident care areas increased the risk of infection transmission to residents, staff, and visitors.

Sources: Observation on a specified date, the Long-Term Care Home's (LTCH) Masking Policy (date reviewed/revised: December 1, 2023), and interviews with Private Caregiver #118 and an IPAC Practitioner.

[000757]