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

Hamilton District
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Original Public Report

Report Issue Date: November 9, 2022	
Inspection Number: 2022-1095-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Baywoods Place Operating Inc.	
Long Term Care Home and City: BayWoods Place, Hamilton	
Lead Inspector Karlee Zwierschke (740732)	**Inspector Digital Signature** Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2022.11.10 10:57:27 -05'00'
Additional Inspector(s) Daria Trzos (561)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 28, 31, 2022
November 1-4, 2022.

The following intake(s) were inspected:

- Intake #00001272 was a complaint regarding resident abuse.
- Intake #00004210 was related to neglect of a resident by staff.
- Intake #00004841 was a complaint regarding abuse of a resident.
- Intake #00006713 was a complaint regarding neglect of a resident.
- Intake #00011812 was a complaint regarding resident care, dining, and laundry services.

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

Infection Prevention and Control
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Resident Care and Support Services
Prevention of Abuse and Neglect

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 #01 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).

Rational and Summary
Additional precaution signage for a room indicated droplet/contact precautions. A personal support worker (PSW) was observed entering this room without the additional PPE that was indicated on the additional precaution signage. Care plan indicated that the resident was on droplet/contact precautions. Interview with IPAC lead confirmed that staff were expected to wear the appropriate PPE as per the additional precaution signage.

IPAC lead identified that droplet/contact precautions were put in place as an additional precaution. This resident did not have any ongoing infections that required droplet/contact precautions. Additional precaution signage removed, and care plan updated.

Sources: Observations, Interview with IPAC Manager, Care plan
Date Remedy Implemented: November 4, 2022. [740732]

WRITTEN NOTIFICATION: Plan of Care

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to them as specified in the plan.

Rational and Summary
A resident's care plan indicated that staff were to work in a pair of two when providing care to the resident. A Personal Support Worker (PSW) provided direct care to the resident by themselves. The Executive Director (ED) confirmed that the care was not provided to the resident as specified in the plan.

Sources: resident's written plan of care; investigation notes; interview with staff. [561]

WRITTEN NOTIFICATION: SDM and Plan of Care

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a 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.

Rational and Summary
A resident's SDM requested the home test the resident as they thought the resident might have had an infection. The physician ordered a test the same day, and the results came back inconclusive. The SDM was upset and thought that the test was never completed, they were not aware of the results of the initial test. The SDM was not aware that staff were completing a second test because the first one was inconclusive. They did not have an opportunity to participate fully in the implementation of the resident's plan of care.

Sources: resident's plan of care; interviews with staff. [561]

WRITTEN NOTIFICATION: Plan of Care

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when care set out in the plan was not effective related to resident's behaviour.

Rational and Summary
The plan of care for a resident indicated that the resident had behaviours related to their diagnosis. The

resident's SDM had also complained about the resident having to wait a long time to be attended to. The report which showed history of call bell response time to attend to the resident identified a number of times when the resident had to wait a long time. There was also a pattern of the longer wait times in the evening shift. The resident's care needs were being met and no identified negative outcome was documented. When the ED reviewed the call history report they acknowledged that some of the wait times were too long. They indicated that they would need to follow up and reassess the plan of care to see if other interventions would be more effective in decreasing the resident's behaviour.

Sources: resident's plan of care; call history report; interviews with staff. [561]