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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: January 26, 2023	
Inspection Number: 2023-1095-0002	
Inspection Type: Critical Incident System	
Licensee: Baywoods Place Operating Inc.	
Long Term Care Home and City: Baywoods Place, Hamilton	
Lead Inspector Erin Denton-O'Neill (740861)	**Inspector Digital Signature** Erin Denton-O`Neill Digitally signed by Erin Denton-O`Neill Date: 2023.02.17 09:40:23 -05'00'
Additional Inspector(s) Jonathan Conti (740882) Inspector #548 (Ruzica Subotic-Howell) was also present during this inspection	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 9-13 and 16-18, 2023, with January 16-18, 2023, conducted off-site.

The following intake(s) were inspected:

- Intake: #00002384-2581-000012-21 - related to Falls Prevention and Management
- Intake: #00008388-2581-000032-22 - related to Falls Prevention and Management

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that there was an Infection Prevention and Control (IPAC) lead in the home whose primary responsibility was the home's IPAC Program.

Rationale and Summary:

The IPAC Lead was scheduled to be in the home on a full-time basis for 37.5 hours a week with the primary responsibility of the home's IPAC program. During an inspection there was no IPAC lead in the home.

The Executive Director (ED) and the Director of Care (DOC) both confirmed that the IPAC Lead that was scheduled in the home was on leave for a period of three months.

The plan while the IPAC lead was on leave indicated that several roles including the ED and DOC would cover the job duties.

If the home has no consistent IPAC lead their program responsibilities may not be completed.

Sources: Interview with Executive Director and Director of Care, record review of the IPAC lead leave plan, observation of the infection control responsibilities,
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WRITTEN NOTIFICATION: Critical Incident Reporting

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that a COVID -19 Outbreak was reported to the Director immediately when the home became aware of an outbreak.

Rationale and Summary:
The home is required to notify the Director immediately of an outbreak of a disease of public health significance.

On November 29, 2022, the home became aware that two residents exhibited symptoms of COVID-19 and tested positive for COVID-19 on a rapid antigen test (RAT). Two staff tested positive on a RAT on November 29, 2022. On November 30, 2022, the home notified the Public Health Unit, and an outbreak was declared. The Director was informed of the outbreak on December 1, 2022, through the Critical Incident system.

Sources: Critical Incident report 2581-000035-22 related to outbreak notification of a COVID-19 outbreak. Note from DOC, Interview with Executive Director and DOC
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WRITTEN NOTIFICATION: Directives by Minister binding on licensees

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every operational Minister's Directive that applies to the long-term care home, the operational Minister's Directive was complied with. In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the Licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that the COVID-19 asymptomatic screen-testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

Rationale and Summary:

A) The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (last updated October 6, 2022) requires the licensee to ensure that all staff, students, and volunteers wear a medical mask for the entire duration of their shift indoors and that visitors and caregivers are required to be masked.

i) On one occasion a staff member was observed walking into an elevator with their mask removed from nose and mouth, hanging from one ear. Several residents were noted in the hallway by the elevator prior to the staff member entering the elevator. The staff member's mask remained off until seeing inspector #740882 and inspector #548 also present in the elevator. The Executive Director acknowledged that the expectation is for all staff and visitors to wear masks.

Failure of the home to ensure the staff member followed universal masking guidelines put the residents at increased risk for infection.

ii)A visitor delivering packages through the main entrance of the home was observed to enter the home without wearing a mask. The visitor walked through the main lobby, bypassed the screener area, and went to the Office Administrators office with packages. The visitor was not stopped by a staff member until the visitor returned from the office area. As the visitor exited the home through the main entrance, a resident was also leaving through the same door and within one foot of the visitor. Three staff confirmed that the visitor was required to wear mask. The Executive Director acknowledged that the visitor should not have entered the home without a mask.

Failure of the home to ensure the visitor followed universal masking guidelines put the residents at increased risk for infection as they were in resident space and within six feet of a resident.

Rationale and Summary:
B) The COVID-19 guidance document for long term care homes (LTCHs) in Ontario requires the licensee to ensure that all general visitors entering a long-term care home must meet one of the following prior to entry:
i) Receive and demonstrate a negative test result from an antigen test taken at the LTCH on that day.
ii) Demonstrate proof of a negative test result from an antigen test or PCR test taken on the same day or the day prior to the visit.

On January 10, 2023, a visitor delivering packages at the main entrance of the home was observed to enter the home without completing a day of, rapid antigen test or confirming with screener proof of a negative test from the previous day. The visitor walked into the main lobby to the office administrator's office, bypassing the screener area. After the visitor returned from the office area, they exited the home after being approached by a staff member. The visitor passed through resident space and was within one foot of a resident when leaving the home. Staff confirmed the rapid testing requirements for all visitors and that procedure was not followed.

Failure of the home to ensure that the visitor completed the COVID-19 asymptomatic screening testing requirements prior to entry posed increased risk of infection for residents as they entered resident space.

Sources: Observations; staff interviews; home's memo titled "COVID-19 IPAC Updates- Rapid Antigen Testing", updated May 19, 2022; home's document titled "Universal Mask Strategy for Staff, Residents and Visitors", dated July 20, 2022; home's document titled "LTC-Screening Guide- COVID-19", updated November 17, 2022; Minister's Directive: COVID-19 response measures for long-term care homes, updated August 30, 2022; COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated December 23, 2022.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to IPAC was followed.

A) The IPAC Standard for Long-Term Care Homes, indicated under additional requirements 10.1 as well as in accordance with the Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014, that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents with 70-90% of alcohol content.

Specifically, the licensee did not ensure that the Alcohol Based Hand wipes contained the required 70-90% alcohol.

Rationale and Summary:

On two occasions in January 2023, it was observed that the Purell hand sanitizer wipes being used in the dining areas on the third floor did not contain the required 70-90% alcohol content.

Sources:
Observations, interview with resident, record reviews of label and PIDAC Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014.

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B) The licensee failed to ensure that the standard for routine practices and additional precautions related to IPAC was implemented. Specifically, that additional precautions were not followed for appropriate removal of Personal Protective Equipment (PPE) upon exiting the resident's room, in accordance with the IPAC Standards for Long Term Care Homes, under section 9.1 (f), April 2022.

Rationale and Summary:
On one occasion a staff member was observed leaving a resident's room who was under additional precautions, requiring use of PPE including mask, gloves, and gown. The staff member removed their gown prior to removal of gloves and confirmed with inspector that PPE was removed in incorrect order. As per the homes policies and PPE removal signage on the resident door, recommended steps for taking off PPE were not followed in correct sequence.

There was an increased risk for spread of infection when the staff member removed PPE in improper sequence after resident care in additional precautions room.

Sources: Interview with staff; observations; the home's procedure titled "PPE Routine Practices and Additional Precautions", dated March 31, 2022

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