Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2015	2014_405189_0003	T-04-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET NORTH YORK ON M6A 2E1

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

NICOLE RANGER (189), JOANNE ZAHUR (589), SOFIA DASILVA (567)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 12,13,14,17,18,20,21,24,25,26,27,28, 2014, December 5, 8, 2014 and January 2, 2015.

The following Complaint inspections were conducted concurrently with this RQI: T-1232-14, T-1368-14,T-1450-14
The following Critical Incidents inspections were conducted concurrently with this RQI: T-406-14, T-809-14,T-1269-14
The following Follow Up inspections were conducted concurrently as part of this RQI: T-1137-14, T-1138-14

During the course of the inspection, the inspector(s) spoke with Vice President Residential, Community & Brain Health, Director of Care, Executive Director of Redevelopment and Support Services, Acting Environmental Service Manager, Administration Assistant, Unit Directors, Dietitian, MDS Coordinator,Volunteer Coordinator, Manager of Consumer Education and Information, Manager of Motion Specialist, physiotherapist, social workers, recreation therapist, activation staff, registered nursing staff, personal support workers, dietary aides, Residents' Council President, Family Council President, private companion, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **4 VPC(s)**
- **2 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	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #23 was protected from abuse by anyone.

Record review and staff interview revealed that from August 2014 to December 4, 2014 staff had witnessed resident #23 to be verbally and physically abused by the residents' spouse on multiple occasions.

The staff members who witnessed the abusive incidents told the inspector that this is an ongoing issue with the resident's spouse and his/her difficulty of understanding the residents' change in condition. Staff members reported that the actions of the spouse are abusive.

Non-compliance to s.19 (1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_163109_0025 on August 25, 2014 with an order issued. The non-compliance in this case was directly related to resident #23 and two other residents who were not protected from abuse by a staff member. The order issued on August 25, 2014 was to ensure that resident #23 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which is was based to the Director.

Record review and staff interview revealed that from August 2014 to December 4, 2014, resident #23 was observed by more than one staff member to be verbally and physically abused by his/her spouse on multiple occasions. The staff did not report these incidents to the Director.

Non-compliance to s.24 (1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_163109_0025 on August 25, 2014 with an order issued. The non-compliance in this case was directly related to resident #23 and two other residents who were not protected from abuse by a staff member. The order issued on August 25, 2014 was to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which is was based to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her 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 his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of residents is fully respected and promoted: the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Staff interview with two identified staff members confirmed that in November 2014, during a change of resident #31 incontinent brief, the resident was not properly cleaned and as a result there was a presence of feces remaining in the resident genitals. The staff members performing the brief change confirmed the presence of feces was not acceptable and demonstrated poor cleaning of the resident.

Interview with the Director of Care (DOC) confirmed that resident #31 was not cleaned and cared for in a manner consistent with his/her needs. [s. 3. (1) 4.]

2. The licensee has failed to ensure that the following right of residents is fully respected and promoted: to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

The inspector observed the Medication Administration Record (MAR) binder to be open to resident's medication administration records on the following occasions:

On November 12, 2014 at 11:30 a.m, on an identified unit, November 14, 2014 at 11:15 a.m, on an identified unit, November 25, 2014 at 11:20 a.m, on an identified unit, November 26, 2014 at 11 a.m, on an identified unit, November 26, 2014 at 11:30 am, on an identified unit.

On each occasion, the MAR binders were open exposing the resident's health information. Staff interview confirms that the MAR binders should be locked and closed to protect the resident's health information. [s. 3. (1) 11. iv.]

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 following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #4: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Record review for resident # 31's care plan indicates honey thickened water at all meals. Review of the posted diet preferences in the kitchen for resident # 31 states no honey

thickened water at lunch. On November 25, 2014, during lunch services, the inspector observed honey thickened water being offered to the resident.

Interview with the registered staff and registered dietitian confirmed that the plan of care and diet preference sheet does not provide clear directions to staff that provide direct care to the resident [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Interview with resident #31's SDM revealed that a toileting care plan was created with the previous unit director to address the care needs of the resident. The current plan of care does not reflect the toileting schedule that was created and is not implemented at present. The new unit director reported to the inspector that he/she is not aware of the toileting schedule for the resident. The care set out in the care plan is therefore not based on the needs and preferences of the resident. [s. 6. (2)]

3. The licensee has failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

On November 25, 2014, during lunch service, the inspector observed that staff offered honey thickened water and honey thickened cranberry juice to resident #31.

Record review of resident #31 diet preferences posted in the kitchen, confirmed that the resident is not to be served these fluids at lunch as per the needs and preferences of the resident.

Interviews with the personal support worker (PSW), dietary aide, registered staff, unit director and nutrition services director confirmed that the resident should not have been offered these liquid items. [s. 6. (7)]

4. Record review and staff interview confirm that resident #24's plan of care indicates that the resident is on a pureed textured diet.

On the afternoon of November 12, 2014, the inspector observed an identified caregiver for resident #24 feeding the resident stewed prunes, to which the resident began to cough frequently. The identified caregiver reported to the inspector that the resident is constipated and he/she made the decision to give the resident the stewed prunes by

"mashing it with his/her hands" to get a softer consistency. The identified caregiver reported that he/she is aware that the resident is to receive pureed prunes, but he/she did not ask the dietary staff for the pureed prunes. Staff interview confirmed that the pureed prunes were available for the resident but the identified caregiver made an independent decision without consulting with nursing or dietary staff. [s. 6. (7)]

5. Record review of resident # 21 plan of care revealed that the resident exhibits responsive behaviours during care and require 2 staff during care. During an interview, staff member G reported that he/she often provides care to resident alone and the resident had on more than one occasion attempted to strike the staff member during care.

Record review of resident # 23 plan of care revealed that the resident exhibits responsive behaviours during care and require 2 staff during care. Staff member H reported that he/she has provided care to the resident alone and the resident attempted to strike the staff during care.

Non- compliance to s.19(1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_163109_005 on August 25, 2014 with an order issued. The order issued on August 25, 2014 required the licensee to develop a process to monitor and evaluate the care being provided to resident # 21 and resident #23, including ensuring at least two staff are present at all time to provide care to residents who require 2 staff. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff.

On November 12, 2014 at 11:00 a.m. on an identified unit, the inspector observed the soiled linen room to be open. The door was unlocked and there was paper towel stuffed into the locking mechanism to prevent the lock from functioning as it should. Interview with the registered staff confirmed that the door should have been locked and staff proceeded to immediately remove the stuffed paper towel from the door.

On November 12, 2014 at 11:15 a.m. on an identified unit, the inspector observed the storage room containing equipment to be wide open. Interview with the PSW confirmed that the door should have been locked. [s. 9. (1) 2.]

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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or medication cart that is secured and locked when unattended.

On November 12, 2014, the inspector observed an unlocked medication cart in the hallway of an identified unit. An identified registered staff was in a resident room conversing with a private care giver and did not have the unlocked medication cart within his/her eyesight.

Interview with the unit director confirmed that the home's expectation for the medication cart is to be locked when not in attendance of the registered staff. [s. 129. (1) (a)]

2. The inspector observed on the following dates the medication cart to be unlocked and unsupervised: November 12, 2014 at 10:30 a.m, on an identified unit, November 14, 2014 at 11:15 a.m, on an identified unit, November 14, 2014 at 11:20 a.m, on an identified unit, November 14, 2014 at 1:15 p.m, on an identified unit, November 21, 2014 at 10:30 a.m, on an identified unit and November 21, 2014 at 11:05 a.m, on an identified unit.

Interview with registered staff confirmed that the medication cart should be locked. [s. 129. (1) (a)]

3. On November 27, 2014, the inspector observed an unlocked medication cart on an identified unit. Registered staff was on break and the inspector was able to open the medication cart and observed resident's medication. Upon return from break, the registered staff confirmed that the medication cart should be secured and locked. [s. 129. (1) (a)]

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 drugs are stored in an area or medication cart that is secured and locked when unattended, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually to discuss the plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker.

Record review and interview with resident #31's Substitute Decision Maker confirmed that the last annual care conference for resident #31 was conducted in September 2013. Interview with a registered staff revealed that the next care conference for resident #31 is not scheduled until January 2015.

Interview with the unit director confirmed that the expectation is that the care conferences are conducted on an annual basis. The unit director confirmed that there was no 2014 annual care conference for resident # 31. [s. 27. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practises and, if there are none, with prevailing practises, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On November 14, 2014, the inspector observed three identified residents wheelchairs to be visibly soiled. Staff interviews revealed that the wheelchairs are deep cleaned every 3 months by an outside company that come to the home. Interview with the manager of the cleaning company revealed the last cleaning of resident's wheelchairs was completed in October 2014, and next scheduled cleaning is for January 2015. Staff reported to the inspector that they do not clean the wheelchairs during the in-between time of scheduled cleaning.

Interview with the unit director confirmed that there is no in between schedule for cleaning the wheelchair and currently no some system in place to ensure the wheelchairs are kept clean [s. 87. (2) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, there are schedules and procedures in place for routine, preventative and remedial maintenance.

On October 30, 2014, the maintenance staff found items that had blocked the drain in an identified resident's washroom. On October 31, 2014, the drain flooded again. The home called an external plumber who found another item blocking the pipes this time. Interview with the executive director for re-development and support services and with the acting environmental manager, revealed that the bathroom pipes in this washroom are configured in a manner that creates improper drainage resulting in flooding of the bathroom . In addition, record review also revealed that this washroom has flooded on at least three occasions within the last two months. The Executive Director for Re-development and Support Services confirmed that the home does not have procedures in place for routine, preventative and remedial maintenance of this identified bathroom drain. [s. 90. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times when not in use.

On the afternoon of November 13, 2014, on an identified home area, the inspector observed keys left inside the medication room door and the door was not locked. On closer inspection, the inspector was able to open the door and observed the treatment cart and medication cart inside the medication room. The inspector observed no registered staff present in surrounding area and called for staff. Registered staff arrived to the area and the inspector pointed out to the staff the keys left in the door and the keys were immediately removed from the door and the door locked. The registered staff confirmed that the keys should not be left inside the door, providing anyone access to the medication room. [s. 130. 1.]

Issued on this 13th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NICOLE RANGER (189), JOANNE ZAHUR (589), SOFIA DASILVA (567)
Inspection No. / No de l'inspection :	2014_405189_0003
Log No. / Registre no:	T-04-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 4, 2015
Licensee / Titulaire de permis :	THE JEWISH HOME FOR THE AGED 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
LTC Home / Foyer de SLD :	THE JEWISH HOME FOR THE AGED (2824) 3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dr. William Reichman

To THE JEWISH HOME FOR THE AGED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0025, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that resident #23, and all residents in the home, are protected from abuse by anyone.
The plan shall include, but not limited to;

How the Licensee will establish an atmosphere and culture that promotes zero tolerance of abuse of any kind in the home.

Please submit the compliance plan to nicole.ranger@ontario.ca by February 20, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #23 was protected from abuse by anyone.

Record review and staff interview revealed that from August 2014 to December 4, 2014 staff had witnessed resident #23 to be verbally and physically abused by the residents' spouse on multiple occasions.

The staff members who witnessed the abusive incidents told the inspector that this is an ongoing issue with the resident's spouse and his/her difficulty of understanding the residents' change in condition. Staff members reported that the actions of the spouse are abusive.

Non-compliance to s.19 (1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_163109_0025 on August 25, 2014 with an order issued. The non-compliance in this case was directly related to resident #23 and two other residents who were not protected from abuse by a staff member. The order issued on August 25, 2014 was to ensure that resident #23 was protected from abuse by anyone. [s. 19. (1)] (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0025, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall prepare,submit and implement a plan to ensure any person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Please submit the compliance plan to nicole.ranger@ontario.ca by February 20, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which is was based to the Director.

Record review and staff interview revealed that from August 2014 to December 4, 2014, resident #23 was observed by more than one staff member to be verbally and physically abused by his/her spouse on multiple occasions. The staff did not report these incidents to the Director.

Non-compliance to s.24 (1) of the Long Term Care Homes Act (LTCHA) was previously identified in inspection 2014_163109_0025 on August 25, 2014 with an order issued. The non-compliance in this case was directly related to resident #23 and two other residents who were not protected from abuse by a staff member. The order issued on August 25, 2014 was to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which is was based to the Director. (189)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NICOLE RANGER

Service Area Office /
Bureau régional de services : Toronto Service Area Office