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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Apr 12, 2016	2016_405189_0002	006752-16	Critical Incident System

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 9, 10, April 6, 2016.

This Critical Incident Inspection is related to fall prevention, transferring and positioning techniques.

During the course of the inspection, the inspector(s) spoke with Director of Care, Unit Director, Registered Staff, Personal Support Workers.

During the course of the inspection, the inspector conducted a tour of the unit, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The written plan of care for resident #001 indicated that the resident requires two staff to transfer via mechanical lift. The written plan of care also indicates that the resident is resistive with care, requires two staff and is at risk for falls.

On an identified date and time, PSW #101 and PSW #102, assisted resident #001 to transfer out of bed and into his/her wheelchair using the mechanical lift. Prior to the transfer, PSW #101 reported to the inspector that the resident had soiled his/her incontinent product and required to be changed. The PSWs were positioned on either side of the bed, and PSW #101 reported that he/she raised the height of the bed and placed the lower ¼ side rail down on the right side in order to take the resident's pants and incontinent product off. PSW #101 reported he/she immediately went into the resident's washroom to place the incontinent product into the hamper. While in the washroom, PSW #101 reported that he/she heard a noise, placed his/her head outside the washroom door, and observed PSW #102 standing at the resident's closet drawers. PSW#101 reported that he/she came outside of the washroom, went towards the bed and observed the resident on the floor, lying on his/her side. The resident was assessed by registered staff #103 and was sent to the hospital. The resident sustained a large laceration to an identified area.

Both PSWs reported to the inspector that they did not observe the resident fall from the bed as they were both away from the bedside at the time. The PSWs reported that the resident is at risk for falls, has a previous history of falls and known to move around while in bed or in the wheelchair.

Interview with registered staff #101 confirmed that it was reported that the resident was left unattended briefly by the PSWs . The Unit Manager confirmed that the PSWs did not use safe positioning techniques and the resident sustained an injury. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, that falls prevention and management training was provided to all staff who provide direct care to residents.

Review of the home's Core Curriculum training records indicated that 30 percent of staff did not complete their training which includes falls prevention and management for 2015.

Interview with the Director of Care confirmed that not all staff who provided direct care to residents received training in fall prevention and management for the 2015 training period. [s. 221. (1) 1.]

Issued on this 10th day of May, 2016

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

Original report signed by the inspector.