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 soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 11, 2017	2017_659189_0015	006977-17	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): June 27, 28, 30, July 4, 5, 6, 2017

This complaint inspection is in relation to personal support services, medication, pain management, skin and wound care, and hospitalization and change in condition.

During the course of the inspection, the inspector(s) spoke with Substitute Decision-Maker (SDM), Administrative Assistant (AA), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Registered Dietitian (RD), Physicians, Client Relations Officer, Medical Director, Associate Director of Care and Resident Experience (ADOC), and the Director of Care and Resident Experience (DOC).

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following were documented: the provision of the care set out in the plan of care.

Record review and staff interview revealed that resident #019 was admitted back to the Apotex LTC unit after a medical leave of absence. Upon readmission to the home, the resident was found to have impaired skin integrity which was acquired during his/her hospital admission. Resident was ordered to receive dressing changes every two days and when needed. A new order for daily dressing changes was ordered on an identified date.

Record review of the Treatment Administration Record (TAR) revealed that the daily dressing changes were not signed by the registered staff on the TAR on four identified dates. Interview with the DOC confirmed that the registered staff did not document on the TAR on the identified dates as required [s. 6. (9) 1.]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

Record review of progress notes revealed that on/around an identified date, resident #019 was demonstrating identified symptoms. PRN medication was given as ordered. Record review revealed from an identified six day time period, resident #019 continued to demonstrate the symptoms daily. PRN medication was given, however it was not given as ordered every four hours. Record review reviewed that on an identified date, resident #019’s SDM requested resident a stronger medication and order was received on an identified date.

Record review and interview with the DOC confirmed that the registered staff did not review and reassess the management of the resident's symptoms when the PRN medication was ineffective.

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 are documented: the provision of the care set out in the plan of care, and 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 care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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.

Record review revealed on an identified date, the physician ordered an identified assessment for resident #019, as the staff reported difficulty with transfers. On an identified date, assessment was conducted with a recommendation for a specialized device to use when transferring the resident. Progress notes revealed until the device was available, an identified number of staff were to transfer the resident manually in and out of bed. Progress notes indicated that primary PSW and RPN were explained the transfer technique.

During staff interviews, RPN #110 and RPN #102 revealed that while the staff were awaiting the arrival of the device, the PSW's were manually getting the resident out of bed and into the wheelchair. Interview with PSW #190 revealed that he/she would manually get the resident up from the bed, however PSW #190 confirmed that the resident was not transferred by the number of identified staff.

Interview with the DOC confirmed that the staff failed to ensure safe transferring techniques when assisting resident #019. [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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Record review revealed that on an identified date, the physician ordered resident #019 to receive a medication three times a day. A review of the Medication Administration Record (MAR) revealed that resident #019 did not receive the medication as prescribed on three identified dates. Interview with the DOC confirmed that the resident did not receive the medication as prescribed by the physician. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

s. 21 - Every licensee of a long term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

A review of the home's policy entitled "Clinical Documentation Policy" created January 2015, indicated that a focused narrative must be recorded whenever a client/family/Substitute Decision maker (SDM) identified a care issue/concern.

On an identified date, a complaint was received at the Ministry related to care received at the home for resident #019. The complainant reported that the nursing staff failed to listen to his/her concerns and subsequently the resident was sent to the hospital and diagnosed with an identified medical condition.

Record review of progress notes revealed that on an identified date, RPN #102 reported that resident #019 had an identified symptom as RPN, PSW and family member noted the symptom. Resident's vitals were assessed and PRN medication was given.

Interview with RPN #102 revealed that on/around an identified date, resident #019's Substitute Decision Maker (SDM) reported to him/her that the resident was exhibiting the

symptom at a particular time of day. RPN #102 reported that he/she assessed the resident when the SDM reported the concerns to him/her, however he/she did not document the SDM's reported concern.

Record review revealed that monitoring was conducted by the registered staff on the subsequent nursing shifts thereafter and the symptom was no longer observed.

Interview with the DOC revealed that the home's expectation was for the registered staff to document any concerns family members or SDM reported to the nursing staff. The DOC further confirmed that RPN #102 did not follow the home's policy on documentation. [s. 8. (1)]

2. r. 114 (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10.

A review of the home's policy entitled " Policy 3.3.1.3: New Orders", dated May 2015, directs the registered staff that new medication orders shall be accurately recorded in the MAR/TAR by the registered staff responsible for processing the new order.

If the order is a dose change, the old order is clearly discontinued by crossing diagonally through the order and putting a vertical line after the last dose administered and drawing a horizontal line through the remaining dates. A notation should be made to the effect of " Dose change, see new order", with the date of the order and initial of the nurse processing the order. Under no circumstances shall the old order be overwritten with the new order. The new order shall be transcribed in the next available blank space in the MAR/TAR.

Record review revealed that on an identified date, the physician ordered resident #019 to receive an identified medication. A review of the Medication Administration Record (MAR) revealed on the PRN Meds page, the PRN medication of the identified medication, was overwritten with a new order.

Interview and review of MAR with the DOC confirmed that the new order for the identified mediation was incorrectly transcribed on the MAR, and that the nurse did not follow the home's policy related to the recording of the new medication on the MAR. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

Record review revealed on an identified date, the physician ordered an identified assessment for resident #019, as the staff reported difficulty with transfers. On an identified date, assessment was conducted with a recommendation for a specialized device for transfers. Record review and staff interview revealed that on an identified date, the staff were using an alternative device to assist with transfers, however due to the impaired skin integrity to an identified area of the body, the alternative device was not appropriate. RPN #110 reported that the Unit Director was informed the alternative device was not appropriate for the resident and required the recommended device in order to be transferred and requested a rush for the specialized device.

Interview with PSW #105, RPN #102 and RPN #110 revealed that the resident required the use of the special device in order to safely transfer the resident out of bed. Record review and staff interview with RPN #110 revealed that the resident did not receive the device until an identified date, while the patient was admitted to the hospital. Interview with the DOC confirmed that the device was not readily available to meet the resident's care needs. [s. 44.]

Issued on this 25th day of August, 2017

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

Original report signed by the inspector.