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 prévue 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2018	2018_530726_0007	011663-18, 022385-18	Critical Incident System

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

REBECCA LEUNG (726)

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): October 19, 22, 23, 24, 25, 26, 29, and Nov 2, 2018, and off-site on November 7 and 21, 2018

The following intakes were inspected concurrently during this inspection:
Critical Incident Log #s:
011663-18 related to abuse,
022385-18 related to abuse.

The sample expansion of all non-compliance identified during this inspection were inspected during Complaint inspection #2018_766500_0018, intakes log #026782-18, 027075-18 by inspector #500.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Unit Manager (UM), Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Administrative Secretary, residents, family member and substitute decision-maker (SDM).

During the course of the inspection, the inspector observed staff to resident interactions, reviewed staff schedule, clinical health records, the home's investigation notes, policy and procedure.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an unwitnessed resident to resident abuse involving resident #001 and resident #002. Review of the CIS report indicated that on an identified date and time, resident #002 was noted to have a specific injury. Cause of the specific injury was unknown, and investigation was initiated by the home. Resident #002's family was informed. The on-call physician assessed resident #002 and ordered a specific investigation. Review of physician's progress note on an identified date indicated that resident #002's identified injury was resolving.

Review of an identified assessment completed on an identified date, indicated that resident #002 was identified with some specific functional issues, and resident #002 required assistance from staff for two identified activities of daily living.

Review of an identified assessment completed on an identified date, indicated that resident #001 was identified with some specific functional issues, and resident #001 required supervision for an identified activity of daily living.

In an interview and the subsequent email clarification on an identified date, UM#108 indicated that they interviewed the staff involved on an identified date and time, and the incident was identified as being potentially caused by resident #001. UM #108 then directed the staff on duty to initiate close monitoring for resident #001 immediately. As the identified injury led to concerns regarding possible resident to resident physical aggression, with the family's consent, resident #002 was transferred to another unit on an identified date.

In an interview, UM #108 indicated that when they were reviewing the surveillance video footage, they saw resident #001 exhibited a specific behaviour. Resident #001 went into resident #002's room twice on an identified date and time; and the second time when resident #001 came out of resident #002's room, resident #001 had a folded blanket on their arm. When the PSW returned from their breaks, they discovered that the blanket belonged to resident #002. UM#108 further indicated that based on the surveillance video footage and the information provided by the staff involved, the home had determined that resident #002's identified injury might have resulted from an unwitnessed possible resident to resident physical aggression which occurred on an identified date and time with resident #001 being the potential aggressor. However, the inspector was unable to establish strong evidence to support a resident to resident abuse as the incident was unwitnessed, and resident #002 was on a specific medication (prior to the date of incident) which might increase their risk of injury; PSW #101, #102, #103, #104, and #107 did not discover resident #002's identified injury despite having repeated close contacts with resident #002 during provision of care in a specific range of time throughout the identified shifts on the identified dates. Resident #002's identified injury was discovered by PSW #103 and #107 when they went to provide resident #002 with care at an identified time on the date of incident.

Review of resident #001's specified assessment completed on an identified date did not indicate that resident #001exhibited the specified behaviour. Review of another identified assessment completed on an identified date, indicated that resident #001 exhibited the specific behaviour on some days during the observation period. However, review of resident #001's plan of care indicated no intervention for management of the specific behaviour was implemented prior to the date of incident.

In an interview, PSW #102 indicated that resident #001 exhibited the specific behaviour most of the time prior to the incident occurred. PSW #102 stated that when they were assigned as the runner PSW, they were responsible to monitor residents exhibiting the

specific behaviour in the unit including resident #001.

In an interview, PSW #104 indicated that resident #001 was known to exhibit the specific behaviour in the unit prior to the incident occurred. In an interview, RN #100 indicated that resident #001 was not identified with exhibiting the specific behaviour prior to the incident occurred.

In an interview, UN #108 indicated that the registered staff had repeated the identified assessment for resident #001 after the incident occurred, and implemented interventions for managing resident #001's specific behaviour including the initiation of close monitoring. [s. 6. (4) (a)]

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

The practice in the home is for the PSW to complete documentation for each resident using a specific template in every shift. The required documentation included the amount of food and beverages consumed, personal care and assistance provided, behaviours observed and safety checks conducted, etc.

During the record review, the inspector was unable to locate the above mentioned specific template documented for residents #001 and #002 for an identified shift on an identified date.

In an interview, PSW #107 indicated they did not document the care provided for resident #001 using the above mentioned specific template for the identified shift on the identified date. PSW #107 acknowledged that they should have documented the care provided for resident #001.

In an interview, PSW #103 indicated they were too busy to document the care provided for resident #002 using the above mentioned specific template for the identified shift on the identified date. PSW #103 acknowledged that they should have documented the care provided to resident #002.

In an interview, UM #108 indicated that during the investigation, they were aware that the PSW did not document the care provided to residents # 001 and #002 using the above mentioned specific template for the identified shift on the identified date. UM #108 acknowledged that the PSW should have documented the provision of care for both

residents. [s. 6. (9) 1.]

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 - ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
- ensure that the provision of the care set out in the plan of care are documented., to be implemented voluntarily.

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 the licensee or staff that resulted in harm or risk of harm to the resident reported the suspicion and the information upon which it is based to the Director.

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an unwitnessed resident to resident abuse involving resident #001 and resident #002. Review of the CIS report indicated that on an identified date and time, resident #002 was noted with a specific injury by the staff. Cause of the specific injury was unknown, and investigation was initiated by the home. Resident #002's family was informed. The on-call physician assessed resident #002, ordered a specific investigation and discussed findings with resident #002's family. The Police were notified by the home on an identified date.

In an interview, resident #002's family indicated they received a call from the staff at an identified time on the date of incident. The family was informed that when the staff went in to provide care for resident #002, they found the identified injury on resident #002. The family visited resident #002 at an identified time on the same day and met with the physician and UM #108. The family stated that during the meeting with UM #108, UM #108 informed that they had reviewed the surveillance video footage for an identified shift on an identified date, and they did not see any other people go into resident #002's room other than the staff. The family then indicated to UM #108 that they were concerned that resident #002 s injury might have resulted from potential staff to resident abuse. UM #108 informed the family that they would interview the staff involved on an identified date. The family reported the incident to the police later on the same day and the police went to the unit to meet with the family.

Review of patient care note recorded on an identified time on the date of incident, the registered staff documented that at an identified time, resident #002's family and two policemen came to the unit and investigated about resident #002's condition, and the RN Resource spoke to the policemen.

In an interview, UM #108 confirmed that when they met with resident #002's family on the date of incident, the family indicated their concern regarding resident #002's identified injury might have resulted from possible staff to resident abuse. However, the home did not submit a CI report or call the after-hours phone number to report the alleged staff to resident abuse to the Director immediately on the date of incident. UM #108 indicated they believed that they needed to wait until the investigation was completed before submitting the CI report to the Director. UM#108 stated that after interviewing the staff involved on an identified date post-incident, they expanded the review of surveillance video footage to the previous shift. They then identified a potential resident to resident physical aggression, in which resident #002's identified injury might be caused by

resident #001. The unit staff initiated close monitoring for resident #001 immediately. As the incident was unwitnessed, UM #108 agreed that they could not exclude the possibility of a staff to resident abuse completely and they had continued to monitor the staff to resident interactions in the unit.

The home did not submit the CI report until an identified date, which was three days after UM #108 received the verbal complaint on the date of incident from resident #002's family regarding the allegation of staff to resident abuse related to resident #002. In the CI report, the home only reported a resident to resident abuse based on the home's investigation results. The CI report did not indicate the allegation of staff to resident abuse from resident #002's family and the related results of home's investigation. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged or suspected incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an unwitnessed resident to resident abuse involving resident #001 and resident #002. Review of the CIS report indicated that on an identified date and time, resident #002 was noted with a specific injury by the staff. Cause of the specific injury was unknown, and investigation was initiated by the home. Resident #002's family was informed. The on-call physician assessed resident #002, ordered a specific investigation and discussed findings with resident #002's family. The Police were notified by the home on an identified date.

In an interview, resident #002's family indicated they received a call from the staff at an

identified time on the date of incident. The family was informed that when the staff went in to provide care for resident #002, they found the identified injury on resident #002. The family visited resident #002 at an identified time on the same day and met with the physician and UM #108. The family stated that during the meeting with UM #108, UM #108 informed that they had reviewed the surveillance video footage for an identified shift on an identified date, and they did not see any other people go into resident #002's room other than the staff. The family then indicated to UM #108 that they were concerned that resident #002 s injury might have resulted from potential staff to resident abuse. UM #108 informed the family that they would interview the staff involved on an identified date. The family reported the incident to the police later on the same day and the police went to the unit to meet with the family.

Review of patient care note recorded on an identified time on the date of incident, the registered staff documented that at an identified time, resident #002's family and two policemen came to the unit and investigated about resident #002"s condition, and the RN Resource spoke to the policemen.

In an interview, UM #108 confirmed that when they met with resident #002's family on the date of incident, the family indicated their concern regarding resident #002's identified injury might have resulted from possible staff to resident abuse. However, the home did not notify the police of the alleged staff to resident abuse immediately on the date of incident. UM #108 indicated they believed that they needed to wait until the investigation was completed before submitting the CI report to the Director. UM#108 stated that after interviewing the staff involved on an identified date post-incident, they expanded the review of surveillance video footage to the previous shift. They then identified a potential resident to resident physical aggression, in which resident #002's identified injury might be caused by resident #001. The unit staff initiated close monitoring for resident #001 immediately. As the incident was unwitnessed, UM #108 agreed that they could not exclude the possibility of a staff to resident abuse completely and they had continued to monitor the staff to resident interactions in the unit.

The home did not notify the police of the alleged or suspected resident abuse incident until an identified date, which was four days after the staff discovered resident #002's identified injury on the date of incident.
[s. 98.]

Issued on this 11th day of December, 2018

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

Original report signed by the inspector.