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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 12, 2019	2019_751649_0008 (A1)	025996-17, 023840-18, 030782-18, 031734-18, 033041-18, 003022-19	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

Amended by JULIEANN HING (649) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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To correct finding for resident #003 on page 6 of the report.

Issued on this 12nd day of June, 2019 (A1)

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

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

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

Amended by JULIEANN HING (649) - (A1)

Amended 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 13, 15, 21, 26, 27, 28, 29, April 1, 2, 3, 4, 5, 8 (off site), 9, 10, 11, 12, and 15, 2019.

The following intakes were inspected:

Log #025996-17/CIS #2824-000042-17 and log #031734-18/ CIS #2824-000054-18 related to prevention of abuse and neglect; log #033041-18/ CIS #2824-000058-18 related to transferring and positioning; log #023840-18/ CIS #2824-000036-18 and log #003022-19/ CIS #2824-000005-19 related to falls prevention and management; and log #030782-18/ CIS #2824-000049-18 related to falls prevention and management and transferring and positioning.

A Compliance Order (CO) related to O. Reg. 79/10 s. 36 and a Voluntary Plan of Correction (VPC) related to LTCHA, 2007, s. 19(1) were identified in Critical Incident System (CIS) Inspection #2019_751649_0008 (CIS Logs #025996-17, #023840-18, #030782-18, #031734-18, #033041-18, and #003022-19) dated May 14, 2019, which were conducted concurrently with this inspection, and issued in that report.

During the course of the inspection, the inspector(s) spoke with Director of Resident Care and Experience (DRCE), managers long term care (MLTCs), administrative secretary, physiotherapist (PT), occupational therapist (OT), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), physiotherapy assistants (PTAs) and residents.

During the course of the inspection the inspectors observed staff to resident interactions, conducted observations of the residents, reviewed residents' health records, investigation notes, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
5 WN(s)
4 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. (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 staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

A CIS report was submitted to the MOHLTC related to fall with injury.

Review of the CIS report and progress notes indicated that on an identified date, resident #003 was found on the floor. On a later date the resident expressed pain to an identified area, the attending physician ordered an x-ray, which the results indicated an injury to an identified body area, and the resident was transferred to the hospital.

Review of resident #003's progress notes indicated that on an identified date, the resident fell from their mobility device because they wanted to get something. On another date, resident #003 was sitting in an identified location, when they fell from their mobility device.

On a later date, the attending physician assessed resident #003 at the request of

the resident's family member. The physician documented that it was unclear from the resident's care plan what the ideal position of the mobility device was and a referral was sent to the OT.

On another date, the OT assessed resident #003 and recommended the position of the mobility device.

On April 10, 2019, 1056 hour Inspector #502 observed resident #003 sitting in their mobility device contrary to the recommended position.

In separate interviews, PSWs #128 and #129 indicated that they usually leave the resident in an identified area and constantly monitor them, because the resident had an identified responsive behaviour. Both PSWs indicated that they could not position the resident in the recommended way.

In an interview RPN #155 acknowledged that the resident's current plan of care was not based on the OT recommendation.

In an interview, MLTC #145 indicated that the registered staff are expected to communicate the OT recommendation to the front line staff. MLTC #145 acknowledged that registered staff had not collaborated with the OT in the implementation of the mobility device [s. 6. (4) (b)]

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 the resident's care needs change or care set out in the plan was no longer necessary.

On an identified date a CIS report was submitted to the MOHLTC related to fall with injury.

Review of the CIS report and progress notes indicated that on an identified date, resident #003 was found in an identified area of the home. On a later date the resident expressed pain to an identified body area, the attending physician ordered an x-ray, which the results indicated an injury of an identified body area, resident was transferred to the hospital.

In separate interviews, PSWs # 128, #129, #151, #152 and #154 indicated that before the resident had the injury, they were walking independently with a mobility

aid. After the injury, the resident required a mobility device and a mechanical lift for transfers.

In an interview, RPN #155 indicated that the resident had a decline in status and the current transfer status was a mechanical lift. After reviewing the resident plan of care on PCC, the RPN indicated that the resident was not reassessed.

In an interview, PT #157 indicated that the resident needed a mechanical lift due to the injury. Within two weeks of participating in the physiotherapy program, the resident's transfer status had improved and was changed from two person to one person assistance as the resident continued to improve.

PT #157 indicated that they were aware that the resident's condition had changed as the PTA reported to them since an identified date, that the resident had declined, not able to stand during their physiotherapy program. PT #157 indicated that they had not received a referral to reassess the resident's transfer status.

PT #157 and MLTC #145 indicated that nursing staff are expected to send a referral to the PT and they were expected to reassess the resident's transfer status. Both PT #157 and manager, long term care #145 acknowledged that the resident had not been reassessed when their condition changed. [s. 6. (10) (b)]

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 and others involved in the different aspects of care collaborate with each other 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 and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 30. (1) every licensee of a long-term care home shall ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the licensee's policy regarding "Fall Risk

Management", revised on April 20, 2015, which is part of the licensee's policies and procedures for Fall management program.

A review of the home's policy titled, Fall Risk Management, revised on April 20, 2015, under Appendix E - Post fall Neurological Assessment indicated that post falls assessment requires registered staff to monitor Head Injury Routine (HIR) as per the schedule on the form post fall assessment that include Glasgow coma scale-eye opening, verbal and motor response. The HIR routine identified on the form for a witnessed fall and the resident hit their head, or for an unwitnessed fall, is every hour (Q1H) for four hours or as per physician order, every four hours (Q4H) for 24 hrs or as directed by the physician order.

A review of the progress notes indicated the resident had several falls during an identified period.

A review of the HIR records for resident #003 identified missing head injury documentation on identified dates.

In interview with RPN #130 they stated that the home's protocol when a resident has an unwitnessed fallen is to assess the resident and initiate the HIR for 24 hours. The RPN indicated that the HIR were not completed as they do not disturb the residents when they are resting.

An interview with the MLTC #145 stated that staff were expected to complete the HIR at the appointed times for resident #003 and acknowledged that they did not. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the MOHLTC on an identified date related to an allegation of abuse involving resident #004.

Further review of the CIS report indicated that resident #004 sustained a fall on an identified date that resulted in an injury which was confirmed in an x-ray report.

Record review and staff interviews indicated that no post fall assessment had been completed after resident #004 fell on an identified date.

In interview with RPN #120, they told the inspector they did not recall if a post fall assessment was available as they did not recall doing one.

In an interview with RPN #121, in response to the question if they were aware that they had to complete a post fall risk assessment in PCC under the assessment tab they responded no.

The home transitioned from Meditech to PCC at the end of October 2018 and is currently in the process of revising their fall policy as it did not direct staff to complete a post fall assessment after a resident fell.

In an interview with RN #123, they acknowledged that no post fall assessment had been completed when resident #004 fell on an identified date. When the inspector asked why the staff had not completed the assessment they responded that they may not have been aware and further explained during that time PCC was new and staff were not aware that they had to complete that assessment.

In interviews with the DRCE and MLTC #116, they both acknowledged that no post fall assessment had been completed when resident #004 fell. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CIS report was submitted to the MOHLTC related to an allegation of abuse involving resident #004.

Further review of the CIS report indicated that resident #004 sustained a fall on an identified date that resulted in an injury which was confirmed in an x-ray report.

A review of resident #004's progress notes indicated that the resident complained of pain to an identified area of the body on identified dates. Further review indicated on an identified date there was documentation that the pain medication given had not been effective.

Record review indicated that no pain assessment had been completed using a clinically appropriate assessment instrument when the resident reported pain to an identified area.

During interviews with RN #123 and MTLC #116, they both acknowledged that a pain assessment had not been completed for the resident when they reported pain. The DRCE was informed that no pain assessment using a clinically appropriate assessment instrument had been completed after the resident fell and reported pain. [s. 52. (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 that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was created and maintained for each resident of the home.

A CIS report was submitted to the MOHLTC related to an allegation of abuse involving resident #004.

Record review indicated that a HIR was started for the resident after the fall on an identified date.

The inspector requested a copy of the HIR document that was started after the resident fell but the home was unable to provide a copy of this record.

During interviews with RN #123 and MLTC #116, they both acknowledged that they were unable to locate a copy of the HIR record for resident #004. [s. 231. (b)]

Issued on this 12nd day of June, 2019 (A1)

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

Original report signed by the inspector.