Ontario

Ministry of Health and Long-Term Care | **Ministère de la Santé et des Soins de longue durée**

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

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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2019	2019_751649_0014	011757-19	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

JULIEANN HING (649)

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): July 31, August 1 and 2, and off-site on August 6, 7 and 9, 2019.

During the course of this inspection non-compliance was identified under r. 36 of the Long-Term Care Homes Act, 2007 (LTCHA, 2007).

Review of the home's Compliance History revealed a history of non-compliance related to the LTCHA, 2007, r. 36. An order was issued under r. 36 during inspection report # 2019_751649_0005 dated May 14, 2019, with a compliance due date of September 30, 2019.

As per policy, a written notice (WN) has been issued under r. 36 with additional evidence for the existing order not past-due.

The following intake was inspected:
log #011757-19/ CIS #2824-000026-19 related to transferring and positioning technique.

During the course of the inspection, the inspector(s) spoke with the manager long term care (MLTC), physiotherapist (PT), registered nurses (RNs and RPNs), and personal support workers (PSWs).

The inspector reviewed residents' health records, staffing schedules, conducted observations, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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	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. (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. (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 written plan of care sets out the planned care for residents #002 and #003.

Resident #002 was selected for sample expansion related to non-compliance identified with resident #001.

On August 2, 2019, at approximately 1115 hours the inspector observed resident #002’s transfer with the mechanical lift using an identified sized sling with two staff.

A review of resident #002’s current care plan indicated that the resident required the use of a mechanical lift with two staff for all transfers. The care plan did not indicate the size of sling to be used with the mechanical lift during the resident’s transfers.

A review of the manufacturer's guide (ARJO) and transfer sling program provided by the home indicated that when a resident required a sling to contact the nurse who will assess and measure the resident for the correct size and type. The guide indicated that based on resident #002’s July 2019 weight they should be using a sling smaller than what was observed to be used. The discrepancy in the size of the sling observed during resident #002’s transfer and the size/ type of sling not indicated in the resident’s care plan nor in the kardex was communicated to the RPN.

Resident #003 was selected for sample expansion related to non-compliance identified with resident #001.

On August 2, 2019, at approximately 1130 hours the inspector observed resident #003’s transfer with the mechanical lift using an identified sized sling with two staff. Based on the manufacturer's guide (ARJO) and transfer sling program provided by the home the correct size of sling had been used during the resident's transfer.

A review of resident #003’s current care plan indicated that the resident required the use of a mechanical lift with two staff for all transfers. The care plan did not mention the size of sling to be used with the mechanical lift during the resident’s transfers.

In an interview with PSW #106, they acknowledged that resident #002 and #003’s care plans and Kardex had not indicated the size of sling to be used for transfer, and explained they had no way of knowing if they were using the correct size of sling. According to the PSW they had used the sling they found hanging in the residents' rooms.

In an interview with MLTC #109, they told the inspector that staff should look in the resident's kardex and if unsure of the sling in the resident's rooms they can ask the registered staff to clarify and acknowledged that the size of the sling should have been identified in residents #002 and #003's care plan and kardex. [s. 6. (1) (a)]

2. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident’s care needs changed or care set out in the plan of care was no longer necessary.

A critical incident system report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to altered skin integrity of unknown cause.

An x-ray report indicated that resident #001 had sustained an injury.

An observation was conducted by the inspector on August 1, 2019, of the resident’s transfer and observed the resident being transferred with the mechanical lift using an identified sized sling with two staff.

A review of the resident’s current care plan indicated that the resident required a smaller

sized sling with the use of the mechanical lift for transfers with two staff.

PSW #105 confirmed the inspector's observation.

The inspector brought the discrepancy of the sling size to the attention of PT #102 who assessed the resident and indicated that the resident should be using the sling size used by the staff and not that identified in the care plan.

In an interview with MLTC #109, they told the inspector that the resident's care plan should have indicated the correct size of sling and went on to explain that the resident had been assessed by PT including transfer training and the expectation was that the PT assessed the appropriate size sling and the care plan should have revised. [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 ensure that there is a written plan of care for each resident that sets out the planned care for the resident and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when that 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. 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 use safe transferring and positioning devices or techniques when assisting resident #001.

A CIS was submitted to the MOHLTC related to altered skin integrity of unknown cause.

An x-ray report indicated that resident #001 had sustained an injury.

Resident #001 was not interviewable.

A review of progress notes and staff interviews indicated that resident #001 was found by PSW #107 with altered skin integrity.

In an interview with PSW #107, who discovered the area of altered skin integrity explained to the inspector when they entered the residents' room they did not observe anything different with the resident. In preparation for the resident's transfer they removed their blanket and pulled the bed out, was bent close to the resident when they noticed an area of altered skin integrity and immediately called the RPN.

Interview with RPN #100 who was notified of the resident's altered skin integrity assessed the site. The physician was called by the RN and an x-ray was ordered. According to the RPN the physician ordered not to move the resident. The inspector inquired from the RPN if there were any concerns from the day shift of the resident hitting themselves and they indicated there were none. The RPN further explained that the area of altered skin integrity may have happened between the time the resident was put back to bed after lunch and when they first saw it. The RPN told the inspector that the resident has an identified responsive behavior and explained that they had not received any recent reports of the resident having this behavior.

Interview with PSW #104 who worked with the resident and helped PSW #108 with the resident's transfer back to bed told the inspector that they both observed the resident had an identified responsive behaviour resulting in them hitting themselves against something. The PSW further explained they had not removed an identified device from the mobility aide as was the established practice in the home. According to PSW #104 they both had checked the resident but did not observe any area of altered skin integrity and therefore had not reported that the resident had injured themselves during the transfer.

Interview with PSW #108 who helped with the resident's transfer acknowledged that they had not removed an identified device from the mobility aide prior to the resident's transfer and explained that the resident had an identified responsive behaviour during the transfer. The inspector inquired if the resident had injured themselves during the transfer and they responded due to the resident's identified responsive behaviour they possibly could have sustained an injury. PSW #108 told the inspector they were not aware that the resident had sustained an injury and denied looking for any area of altered skin

integrity.

According to PSW #104 the resident had an identified responsive behaviour whereas PSW #108 could not recall where the resident had injured, neither staff acknowledged the resident injuring themselves.

A letter obtained from the home addressed to PSWs #104 and #108 indicated they both had acknowledged that the resident had sustained an injury on their mobility aide during the transfer and they had not removed an identified device as was the established practice in the home.

In an interview with MLTC #109, they told the inspector that when the PSWs saw that the resident had been injured themselves they should have brought it to the attention of the registered staff.

In conclusion, given that PSWs #104 and #108 both acknowledged to the home that the resident had sustained an injury on the mobility aide during the transfer and had not reported this to the nurse clearly demonstrates that safe transferring and positioning devices or techniques had not been used.

The severity of this non-compliance was identified as actual harm, the scope was identified as isolated. Review of the home's compliance history revealed a compliance order (CO) order was issued on May 14, 2019, under inspection report #2019_751649_0005 dated May 14, 2019, with a compliance due date of September 30, 2019.

As per policy, a written noticed (WN) has been issued under r. 36 with additional evidence for the existing order not pass-due. [s. 36.]

Issued on this 9th day of September, 2019

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

Original report signed by the inspector.