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

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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 15, 2019	2019_641665_0020	019263-19, 019420-19	Complaint

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

JOY IERACI (665)

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): October 16, 17, 18, 22-25, 2019. Off site October 29 and 30, 2019.

The following intake logs were inspected:
-Complaint Log #019263-19 related to allegation of abuse and plan of care concerns
-Critical Incident System (CIS) Log #019420-19, CIS #2824-000051-19 related to the same issue

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6(7) was identified in this inspection and has been issued in Inspection Report #2019_641665_0019, dated November 15, 2019, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long Term Care Manager (LTC Manager), Assistant to the ED (AED), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspectors observed staff and resident interactions, reviewed clinical health records, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff #130 who provided direct care to resident #004 was kept aware of the contents of the resident's plan of care.

The Ministry of Long Term Care (MLTC) received a complaint through the ACTIONLine on an identified date in 2019 related to care concerns of resident #004.

In an interview, the complainant stated that the resident was on a specified nutrition and hydration intervention and had an identified schedule in place. The complainant indicated that on an identified date in 2019, staff was not aware that the resident was scheduled to receive the intervention at an identified time (A).

A review of the resident's current plan of care indicated that the resident was on a specified nutrition and hydration intervention. The plan of care specified the nutrition intervention had an identified schedule in place. The plan of care indicated that the resident was scheduled to receive the intervention at an identified time (A) mentioned above.

In an interview, RPN #130 indicated that on the identified date in 2019, resident #004 requested a specific item when the resident was scheduled to have the specified item (A). The RPN was aware that the resident was on a specified intervention and schedule; however, was not aware that the resident was allowed the item at the identified time (A) noted above. The RPN indicated they looked at a specified nutrition and hydration sheet for the resident, but missed reading that resident #004 was allowed the specified item at the identified time (A), until it was brought to their attention by the complainant. RPN #130 stated they provided the resident their specified item and confirmed they were not aware of resident #004's nutrition and hydration plan of care.

In an interview, LTC Manager #111 stated that it is an expectation for staff to know the contents of the resident' care plan at the start of their shift. The LTC Manager was aware of the incident on the identified date in 2019, and acknowledged that RPN #130 was not aware of the contents of resident #004's plan of care related to their nutrition and hydration. [s. 6. (8)]

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 staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, 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. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that RN #132 who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.

In an interview, RN #132 stated that they did not receive training on prevention of abuse and neglect for 2018. The RN indicated that they would work in the home on a casual basis for years, since the home opened.

Review of the home's staffing schedule with staff #128 indicated that the RN worked in the home in 2018. The home was unable to provide documentation that the RN received prevention of abuse and neglect training in 2018.

In an interview, staff #128 indicated that RN #132 picked up shifts and worked as a casual staff. Staff #128 indicated that RN #132 had not been set up on Surge Learning to receive the annual training required by staff working in the home, which included prevention of abuse and neglect training.

The home has failed to ensure that RN #132 who provided direct care to residents received prevention of abuse and neglect training. [s. 221. (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 all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act, to be implemented voluntarily.

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.