Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 26, 2020	2020_641665_0005	020969-19, 021843-19, 022722-19, 023589-19, 000461-20, 002604-20	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

JOY IERACI (665), NATALIE MOLIN (652)

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): February 10-13, 18-21, 24, 25, 26 and 28, 2020. Off site interviews March 2, 3 and 4, 2020.

The following intake logs were inspected:

Follow up log #020969-19 related to plan of care;
Critical Incident System (CIS) Logs:
- #021843-19/CIS #2824-000060-19;
- #022722-19/CIS #2824-000040-19;
- #000461-20/CIS #2824-000002-20 and
- #002604-20/CIS #2824-000002-20, all related to falls prevention and management;
- #023589-19/CIS #2824-000066-19 related to prevention of abuse.

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 #2020_641665_0007, dated May 26, 2020, 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), Physicians (PHY), Registered Dietitian (RD), Food Services Manager (FSM), Physiotherapist (PT), Occupational Therapist (OT), Unit Managers (UM), Nursing Informatics (NI), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Staff (ES), Private Companions (PC), family members and residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2019_817652_0019	652

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 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 resident #005 had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Ministry of Long term Care (MLTC), related to an alleged fall of resident #005. A description of the incident in this CIS indicated that on an identified date in 2019, resident #005 sustained an identified area of altered skin integrity of unknown origin. Resident #005's substitute decision maker (SDM) reported to UM #103, that they were not informed of the incident, resident #005 had an identified injury, was unable to weight bear the prior evening and suspected resident #005 might have fallen. This report mentioned, upon assessment by the RN, the nurse noted; identified areas of altered skin integrity. Resident #005 complained of pain to their SDM when UM #103 assessed an identified area.

Record review of resident #005's progress notes the day after the incident indicated there was no documentation to support resident #005 sustained a fall and had been assessed as a result of a fall. There was no evidence that a post fall assessment had been completed for resident #005.

A Fall Risk Assessment was completed for resident #005, two days after the alleged fall.

In an interview PSW #134 indicated resident #005 did sustain a fall and they reported the fall to RPN #135.

In an interview RPN #135 indicated they were not informed by PSW #134 that resident #005 sustained a fall. The PSW reported resident #005 was sitting in bed and had an identified area of altered skin integrity.

UM #103 verified that the outcome of the home's investigation concluded that PSW #134 did report to RPN #135 that resident #005 sustained a fall and RPN #135 did not assess resident #005 post fall and failed to document.

This non compliance is issued as staff failed to ensure a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls for resident #005. [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.

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.