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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 2, 2020	2020_650565_0008	003314-20, 009999-20	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

MATTHEW CHIU (565), 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): On-site on July 21, 22, 23, 24, 27, 28, 29, 30, 31, August 4, 5, 6, 7, 10, and 11, 2020. Off-site on August 12, 13, 17, 18, and 19, 2020.

During the course of the inspection, the Critical Incident (CI) intake logs #003314-20 and #009999-20 related to prevention of abuse were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long Term Care Managers (LTCM), Human Resources Manager (HRM), Medical Doctors (MD), Infection Control Practitioner (ICP), Registered Dietitians (RD), Food Services Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Staff, Housekeeping Staff, Private Companions (PC), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

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

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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respected and promoted resident #003's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

A CI report was submitted to the Ministry of Long-Term Care (MLTC) related to a staff to resident physical abuse incident involving resident #003.

Review of the home’s investigation records and progress notes indicated that resident #003 was checked for injury or pain and none noted. The home’s investigation concluded the allegation of abuse was not substantiated.

Interview with MD #115 indicated they assessed resident #003 on the identified date. The resident had reported no pain and there was no injury observed.

In the first interview with resident #003, the resident stated that they did not remember the incident. In the second interview with resident #003, they did not answer any question that was related to the incident.

In an interview, SDM #102 stated that on the date of the incident while PSW #100 was providing care for resident #003, they heard resident #003 scream and say stop. After the care, SDM #102 noticed the resident was unhappy and very upset. Resident #003 told SDM #102 that PSW #100 did an action towards them. SDM #102 further stated they kept a record of the conversation that described the action.

Review of the record indicated that on the day of the incident, resident #003 described some details of the incident including PSW #100 ignored the resident’s request and did not stop.

In an interview, PSW #100 stated that on the day of the incident, resident #003 had a specified care need. The PSW described their action and care provided to the resident during that time.

Review of the home’s records indicated PSW #100 was advised to always remember the residents’ rights during every interaction, and ensuring the residents were treated with respect and dignity.

The above-mentioned record indicated PSW #100 did not stop providing the care when the resident requested and did not communicate with the resident. The home has failed to ensure that PSW #100 respected and promoted resident #003's right to be treated with courtesy and respect. [s. 3. (1) 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 to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

For the purpose of the Act and the Ontario Regulation 79/10, “physical abuse” means the use of physical force by a resident that causes physical injury to another resident.

Review of a CI report revealed an unwitnessed altercation happened between resident #001 and #002. As a result, resident #001 sustained physical injuries.

Record review indicated on the day of the incident, staff found residents #001 and #002 were beside each other in an identified home area and the staff took a specified action. Resident #001 described what happened and stated resident #002 used physical force towards them. As a result, resident #001 sustained the injuries.

Interviews with PSW #112 and RPN #113 indicated the above-mentioned incident had happened. On that day, PSW #112 first responded to the incident and then RPN #113. The staff members took subsequent actions and they found resident #001 sustained the injuries. Resident #001 told the staff members separately what had happened and stated resident #002 used physical force towards them and caused their injuries. Upon assessments, RPN #113 found resident #001 sustained the physical injuries whereas resident #002 was not injured.

Interviews with RPN #113 and the DOC indicated the home had developed and implemented strategies to prevent a similar incident between residents #001 and #002 from happening in future. The DOC acknowledged the home had failed to protect resident #001 from physical abuse by resident #002. [s. 19. (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 to protect residents from abuse by anyone, to be implemented voluntarily.

Issued on this 8th day of September, 2020

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

Original report signed by the inspector.