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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Amended Public Copy/Copie modifiée 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
Oct 16, 2020	2020_650565_0009 (A1)	011227-20	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

Amended by REBECCA LEUNG (726) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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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

Please note no change was made in this report.

Issued on this 16th day of October, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Amended by REBECCA LEUNG (726) - (A1)

Amended 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): On-site on 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 Complaint intake log #011227-20 related to hospitalization and change in condition, personal support services, and nutrition care of resident, was inspected.

A Written Notification related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7), identified in concurrent inspection #2020_650565_0007 (log #013177-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Long Term Care Managers (LTCM), Medical Doctors (MD), Registered Dietitian (RD), Food Services Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Family Member.

The inspector conducted record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

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

1 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 care set out in resident #004 and #007's plans of care was provided to the residents as specified in the plan.

a. The Ministry of Long-Term Care (MLTC) received a complaint related to improper care for resident #004. One of the care areas was related to the resident's plan of care during an identified period.

Record review indicated on an identified date, resident #004's family communicated with the team and RD #138 related to the nutrition care for the resident. The record further stated subsequent communications among the family, RD #138, and the team for developing a nutritional care plan for resident #004 in relation to their specified care concern and needs.

On an identified date, the progress notes recorded a specified concern related to resident #004's meal and supplement consumptions. Staff will try offering the supplement in a specified way to accommodate the resident's preference. On the next day, RD #138 confirmed resident #004's nutritional plan with the family and stated the supplement will be prepared in the specified way for resident #004. Further review of the identified record indicated it specified the instructions for preparing the supplement for the resident.

Interviews with PSWs #135, #136, and #137 who served resident #004's lunch meal services during the identified period indicated PSW #135 did not recall how the supplement was served to the resident. PSWs #136 and #137 stated they did

not serve the supplement as specified above.

Interview with FSM #142 indicated the above-mentioned plan was implemented on the identified date. The supplement should have been prepared by dietary according to the specified instructions. FSM #142 acknowledged that the supplement was not provided to resident #004 as specified in the plan.

b. The MLTC received a complaint related to improper care for resident #004. One of the care areas was related to the resident's plan of care related to change in resident's conditions.

Review of resident #004's progress notes stated a discussion between MD #152 and the family was held to review the specified options related to the resident's conditions. The note further stated a specified direction to staff if the resident demonstrates a specified health condition. On the next day, the progress note recorded RN #146 found resident #004 demonstrated the specified health condition and contacted the family. There was no record indicating the specified direction was taken by the staff.

Interview with resident #004's family stated on the identified date and time, they spoke with a nurse and were told that the resident did not have the specified health condition. Approximately three hours later, the family received a call from RN #146 saying that the resident had the specified health condition.

Interview with RN #146 indicated on the identified date when they checked resident #004, they found the resident with the specified health condition and they called the family. The RN stated they did not recall if they had taken the specified direction. The RN further stated if they did, they would document it.

Interview with LTCM #141 indicated that the progress note is part of the resident's plan of care. If MD wrote the specified direction as above-mentioned, staff should follow the specified direction when the resident demonstrated the specified health condition.

Interview with MD #152 indicated that on the identified date, after discussion with resident #004's family, they documented the plan in the progress notes. The MD further stated the plan specified the direction to staff when the resident demonstrates the specified health condition, and staff should have followed the direction as required. MD #152 stated when resident #004 demonstrated the

specified health condition as above mentioned, the specified direction was not followed by staff.

This non-compliance is issued as the home failed to ensure the care set out in resident #004's plan of care was given as specified in the plan. [s. 6. (7)]

2. The MLTC received a complaint involving resident #007 related to the plan of care.

Record review of resident #007's plan of care indicated the resident required the specified assistance for bed mobility.

On the identified date and time, the inspector observed PSW #144 provided care to resident #007. During the provision of the care, PSW #144 assisted resident #007's bed mobility in a specified manner that included turning and repositioning the resident. The assistance provided by PSW #144 was not the same as specified in the resident's plan.

In an interview, PSW #144 stated they were aware that it was written in the plan of care that resident #007 required the specified assistance for bed mobility. However, they did not know that bed mobility included turning or repositioning the resident from side to side in bed. They thought bed mobility only meant pulling the resident up in bed, which they always did with the specified assistance. PSW #144 acknowledged that it would be safer to reposition resident #007 with the specified assistance.

In an interview with the unit charge nurse, RPN #147 said that they were unsure what was written in resident #007's plan of care regarding the assistance required for bed mobility. RPN #147 stated that PSW #144 should have monitored resident #007 while they were turning the resident in bed. RPN #147 stated that resident #007 likely required the specified assistance for bed mobility to ensure their safety.

In an interview, LTCM #128 acknowledged that PSW #144 should have followed the plan of care and assisted resident #007 for bed mobility with the specified assistance.

A Compliance Order #001 related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) was issued under inspection #2020_641665_0007 on May 26, 2020, with a

compliance due date of November 13, 2020. The findings of non-compliance related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) identified under this inspection are being served as additional evidence that supports the existing order not past-due. [s. 6. (7)]

3. The licensee has failed to ensure that resident #004's plan of care was revised when the resident's care needs change.

The MLTC received a complaint related to improper care for resident #004. One of the care areas was related to the resident's plan of care during an identified period.

Progress notes recorded the family's request related to resident #004's feeding assistance.

Further review of the resident #004's plan of care indicated the resident required set up assistance for eating. It was last revised approximately nine months before the above-mentioned identified period.

Record review and interview with PSW #135 indicated they served lunch meal services to resident #004 on two identified dates. The PSW recalled during that time, the resident had a specified change in their health condition. The PSW stated they did not provide the resident with the specified assistance for eating.

Record review and interview with PSW #137 indicated they served lunch meal services to resident #004 on two identified dates. The PSW recalled the resident did not eat much during the identified period. They stated the resident required set up assistance for eating, and they encouraged the resident to eat.

Record review and interview with PSW #136 indicated they served lunch meal services to resident #004 on two identified dates. Towards the identified period, the resident required increased assistance for eating but the resident was not eating much during that time.

Record review and interview with PSW #139 indicated they served dinner meal services to resident #004 on five identified dates. The PSW recalled the resident required increased assistance the last several days of the identified period. The PSW stated on the identified date when they provided the specified change in the resident's eating assistance, the resident consumed the food well.

Interview with RPN #140 indicated towards the end of the identified period, the resident had a change in their health condition, and they required the specified change in their eating assistance. The RPN further stated the resident always required encouragement for eating, otherwise they would say they don't want the food.

Interviews with RPN #140 and FSM #142 indicated as the resident had the specified change in their health condition, they required the specified change in the assistance for their eating care needs. The staff members confirmed resident #004's plan of care for feeding assistance was not revised when their care needs 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 the plan of care is reviewed and revised at any other time when the resident's care needs change, to be implemented voluntarily.

Issued on this 16th day of October, 2020 (A1)

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

Original report signed by the inspector.