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_0007 (A1)	012703-20, 013177-20, 013181-20	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

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Please note the following changes have been made in this report due to errors of staff identification number:
- on page 7, the third and seventh paragraph, RD #148 was identified as RD #147
- on page 9, the fourth paragraph: RPN #134 was identified as RPN #143
All the above-mentioned errors have been corrected to reflect the accurate staff identification number.

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

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 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 following Complaint intake logs were inspected:

- #012703-20 related to minimizing of restraining of resident,

- #013177-20 related to infection prevention and control, personal support services and nutrition care of resident, and

- #013181-20 related to housekeeping services, Residents' Bill of Rights, personal support services and nutrition care of resident.

A Written Notification related to LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) was identified in this inspection and has been issued in Inspection Report #2020_650565_0009, dated September 2, 2020, which was conducted concurrently with this inspection.

A Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 229 (4), was identified in this inspection and has been issued in Inspection Report 2020_840726_0009, dated September 2, 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), 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:

Accommodation Services - Housekeeping
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

- **3 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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006's plan of care was based on, at a minimum, interdisciplinary assessment of the sleep patterns and preferences with respect to the resident.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident #006's sleep preferences.

Review of resident #006's progress notes indicated the resident had an identified health condition related to their sleep and it stated staff to clarify the care related to the resident's sleep at night. Review of resident #006's plan of care indicated the resident had both cognitive and physical impairment and it did not specify their sleep patterns and preferences.

Interviews with PSWs #109 and #111 indicated the specified care for resident #006 related to their sleep during the day varied. The PSWs stated the resident's plan of care did not mention their sleep pattern and preferences.

Interviews with PSW #112 and RPN #113 indicated the resident's bed time routine varied. The staff members stated the resident's sleep pattern and preferences were not specified in the resident's plan of care.

Interview with LTCM #114 indicated resident #006 should have a plan related to their sleep patterns or preferences. The LTCM confirmed their plan of care was not based on interdisciplinary assessment of the sleep patterns and preferences as required. [s. 26. (3) 21.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the sleep patterns and preferences with respect to the resident, to be implemented voluntarily.

WN #2: 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 :

(A1)
1. The licensee has failed to ensure that PSW #144 and RPN #147 who provided direct care to resident #007 were kept aware of the contents of resident #007's plan of care and had convenient and immediate access to it.

The MLTC received a complaint related to the specified care concern for resident #007.

Record review indicated resident #007 had cognitive impairment and required a specified level of assistance for care. On an identified date, RD #148 recorded the dietary requirements, their assessment and recommendations in the progress notes, and stated they liaised with the team regarding the specified care for the resident.

Review of resident #007's Kardex and care plan indicated the specified care was not written there.

Interview with PSW #144 indicated they were not aware of the specified care for resident #007. PSW #144 acknowledged that the specified care should have been transcribed to resident #007's Kardex to ensure the PSWs had convenient and immediate access to the information.

Interview with RPN #147 indicated they were not aware of the specified care for resident #007. RPN #147 acknowledged that the specified care should have been transcribed to resident #007's care plan and Kardex to ensure the registered staff and PSWs had convenient and immediate access to the information.

In an interview, RD #148 stated that on the identified date, they updated resident #007's progress notes with the specified care and reviewed the information with the team. RD #148 stated the specified care contained care information specific to resident #007 and acknowledged that they should have been written in resident #007's Kardex to ensure the direct care staff had convenient and immediate access to the information.

The home has failed to ensure that PSW #144 and RPN #147 who provided direct care to resident #007 were kept aware of the specified care written in resident #007's plan of care and had convenient and immediate access to it. [s. 6. (8)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that resident's #008's wheelchair was kept clean and sanitary.

During the inspection of multiple care areas related to resident #008, multiple observations for the cleanliness of their wheelchair were conducted by Inspector #565 on five identified dates. The inspector observed resident #008's wheelchair had patches of white stains and dirt on its headrest, armrests, and metal frame. They were more intense on the left armrest and the metal frame near the wheels and leg rests where patches of brownish marks and dirt were observed.

Some of the above observations were conducted together with staff members and Inspector #726 as follows:
- On two identified dates, observations together with PSW #132 and RPN #134 respectively, Inspector #565 observed the cleanliness of the wheelchair as stated above. The staff members commented the wheelchair was dirty and RPN #134 stated they will notify the family to find out if they want to send it for cleaning for a small fee.
- On an identified date, observations together with LTCM #114, the DOC and ED, Inspector #565 observed the cleanliness of the wheelchair as stated above. The DOC commented they did not see an unclean wheelchair and the ED commented it could be rust. Subsequent observation together with Inspector #726 indicated consistent findings with Inspector #565 as stated above.

Interviews with PSW #132, RPN #134 and the ED were unable to identify when the wheelchair was last cleaned. The ED further commented their observation was that resident #008's wheelchair was perfectly clean, and it may have dust in the wheels.

Non-compliance was issued base on the above observations that resident #008's wheelchair was found not kept clean and sanitary on the above-mentioned days. [s. 15. (2) (a)]

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.