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_840726_0009 (A1)	011431-20	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

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

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

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

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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): July 27-28, 31, August 5, 7, 10-11, 2020, and off-site on July 29-30, 2020.

The following Complaint intake was inspected during this inspection:

Log #011431-20 related to plan of care, transfer and positioning, infection prevention and control.

PLEASE NOTE: A Written Notification and a Voluntary Plan of Correction related to O. Reg. 79/10, s. 229 (4), identified in a concurrent inspection #2020_650565_0007 (Log # 013177-20) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Long-Term Care Manager, Registered Dietitian, Food Services Manager, Infection Control Practitioner, Registered Practical Nurses (RPN), Personal Support Workers (PSW), family member and the resident.

During the course of the inspection, the inspectors reviewed residents' health records, observed the provision of care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Personal Support Services

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

2 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSWs #117, #119 and #144 participated in the implementation of the infection prevention and control program.

The Ministry of Long-term Care (MLTC) received a complaint involving resident #005 related to plan of care, transfer with mechanical lift and the implementation of infection and prevention control program during the pandemic.

1. On an identified date and time, the inspector conducted an observation of a transfer with mechanical lift and the provision of continence care for resident #005 by PSW #117 and PSW #118 inside resident #005's room.

During the observation for the provision of continence care, the inspector observed both PSWs put on gloves before starting the procedure. Towards the end of the care procedure, the inspector observed PSW #117 remove the soiled brief from the resident and did not change their gloves afterwards. PSW #117 continued working with the same pair of gloves on their hands and touched the drawer on the bedside table, the bed linen and a device for positioning.

In an interview, PSW #117 acknowledged that they should have changed their gloves after removing the soiled brief from resident #005, before touching the clean area and supplies.

In an interview with the unit charge nurse, RPN #127 acknowledged that PSW #117 should have changed their gloves after providing continence care and removing the soiled brief from resident #005, before touching clean area and supplies.

2. On an identified date and time, the inspector conducted another observation of a transfer with mechanical lift and the provision of continence care for resident #005 by PSW #119 and PSW #120 inside resident #005's room.

During the observation for the provision of continence care, the inspector observed both PSWs put on gloves before starting the procedure. Towards the end of the care procedure, the inspector observed PSW #119 remove the soiled brief from resident #005 and threw it onto the floor. PSW #119 did not change their gloves afterwards. PSW #119 continued working with the same pair of gloves on their hands and touched the drawer on the bedside, resident’s clothes,

and the device for transfer.

In an interview, PSW #119 stated they did not usually change their gloves after providing continence care unless the resident had a bowel movement. PSW #119 acknowledged that they should have changed their gloves after removing the soiled brief from resident #005 before touching the clean area and placed the soiled brief into the garbage can instead of throwing it on the floor.

In an interview with the unit charge nurse, RPN #122 acknowledged that PSW #119 should have changed their gloves after removing the soiled brief from resident #005 before touching the clean area and placed the soiled brief into the garbage can instead of throwing it on the floor.

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

On an identified date and time, the inspector conducted an observation of the provision of continence care for resident #007 by PSW #144 inside resident #007's room.

During the observation, the inspector observed PSW #144 put on gloves before starting the procedure. Towards the end of the care procedure, the inspector observed PSW #144 remove the soiled brief from resident #007 and did not change their gloves afterwards. PSW #144 continued working with the same pair of gloves on their hands and touched the drawer on the bedside table, the bed linen and resident’s clothes.

In an interview, PSW #144 acknowledged that they should have changed their gloves after providing continence care and removing the soiled brief from resident #007, before touching the clean area, resident's clothes and bed linen.

In an interview with the unit charge nurse, RPN #147 acknowledged that PSW #144 should have changed their gloves after providing continence care and removing the soiled brief from resident #007, before touching the clean area, resident’s clothes and bed linen.

In an interview, the Infection Control Practitioner (ICP) stated that if the direct care staff were wearing gloves while providing care to the residents and the care

involved touching of the resident's body fluid, the staff should change their gloves before touching the clean area. The ICP stated the principle was that when the staff working from dirty to clean area, they should perform hand hygiene before donning new pair of gloves. The ICP acknowledged that PSW #119 should have discarded the soiled brief in the garbage can, instead of throwing it on the floor.

In the interviews, the Long-term Care Manager (LTCM #128) acknowledged that the PSWs #117, #119 and #144 should have changed their gloves after providing continence care and removing the soiled brief from residents #005 and #007 before touching the clean area, and PSW #119 should have placed the soiled brief into the garbage can instead of throwing it on the floor.

4. On an identified date and time, outside resident #010's room, the inspector observed the sign of Special Contact and Droplet Precautions and the procedures for donning and doffing personal protective equipment (PPE) posted outside the door of resident #010's room. The inspector observed PPE supplies including gloves, gowns and face shields except surgical mask were stored in a caddy hanging outside the door. The inspector then observed PSW #119 keep their source mask on and put on gown, gloves and face shield, then entered resident #010's room.

When PSW #119 came out of the resident's room later, the inspector observed PSW #119 wearing a mask on them only. In the interview, PSW #119 stated that they just finished providing personal care for resident #010 and had removed the gown, face shield, gloves, and performed hand hygiene before coming out of the resident #010's room. When the inspector asked PSW #119 if they had changed the mask before coming out of the resident's room, PSW #119 stated that they did not change their mask. The inspector then asked PSW #119 if they were supposed to change their mask after providing personal care to resident #010 according to the home's policy. PSW #119 apologized and acknowledged that they should have changed the mask after providing care for resident #010.

Review of the progress note written by RPN #127 on an identified date, indicated that resident #010 was put on special contact and droplet precautions as per infection prevention and control (IPAC) instructions due to respiratory symptom observed. Swab for COVID-19 test was taken on that day.

In an interview, RPN #122 stated that they used to keep the mask in the PPE

caddies, but the masks were disappearing. They were told by the management team to keep all surgical masks inside the medication cart and locked. RPN #122 said that before providing care for the residents on special contact and droplet precautions, the PSWs were supposed to obtain a new mask from the unit charge nurse prior to going inside the resident's room. RPN #122 acknowledged that PSW #119 should have changed their mask after providing care for resident #010.

In an interview, the ICP confirmed that the staff were required to change their masks after providing care for residents on special contact and droplet precautions for COVID-19 suspected or confirm cases.

In an interview, LTCM #128 acknowledged that PSW #119 should have changed their mask after providing care for resident #010 who was on special contact and droplet precautions.

The home has failed to ensure that PSWs #117, #119 and #144 participated in the implementation of the home's infection prevention and control program. [s. 229. (4)]

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 ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 70. Dietary services
Every licensee of a long-term care home shall ensure that the dietary services component of the nutrition care and dietary services program includes,
(a) menu planning;
(b) food production;
(c) dining and snack service; and
(d) availability of supplies and equipment for food production and dining and snack service. O. Reg. 79/10, s. 70.

Findings/Faits saillants :

1. The licensee has failed to ensure the nutrition care and dietary services program includes the availability of supply of a specified food item for resident #005 as per the plan of care.

The MLTC received a complaint involving resident #005. The complainant stated that the resident had been taking a specified food item daily to prevent the recurrence of a specified infection as recommended by the specialist. The complainant reported that during the pandemic, the home was unable to supply the specified food item and it was not provided to resident #005 for some time.

Review of the note for an identified date written by the registered dietitian (RD # 131), indicated that resident #005 was receiving a supplement mixed with the specified food item twice a day prior to the pandemic.

Review of RD note for an identified date, indicated that they spoke to resident #005's family member, that the home was unable to provide resident #005 with the specified food item at that time. Resident #005’s family member stressed that the specified food item was used like a medicine and the resident was recommended to use it to prevent the specified infection by a specialist. RD note indicated the resident's health condition was stable at that time. Resident #005’s family member requested to bring in the specified food item. RD #131 explained that due to current COVID-19 policies, family members were not able to bring in parcels from home. RD #131 indicated that they emailed the nursing team, physician and unit manager, and spoke with RPN #127 and recommended mixing

the supplement into another food since the specified food item was not available. Review of RD note for an identified date, indicated that resident #005's family member was agreeable to mix the supplement into another food item. The note further indicated RD #131 communicated with the physician to evaluate the alternatives for preventing the specified infection.

In the interviews, RD #131 said that they reviewed resident #005's clinical records and spoke with the staff involved and found that resident #005 had missed the specified food item for about one week in April. RD #131 stated that resident #005 did not experience any recurrence of the specified infection related to this incident.

In an interview, the food services manager (FSM #142) stated that their major food supplier did not carry the specified food item, and they had been purchasing the specified food item from the local food stores on a weekly basis. FSM #142 stated that during the pandemic, they were unable to purchase the specified food item from the local food stores and the unit was totally out of supply for three days in April 2020. In a follow up email with the FSM, they indicated that in the situation where the home is not able to obtain supply of the specified food item in the future, they would discuss with the SDM for an alternate plan.

The nutrition care and dietary services program failed to ensure the availability of supply of the specified food item for three days for resident #005 as per the plan of care, and the home was not able to articulate a plan that would ensure the availability of the specified food item in the future. [s. 70. (d)]

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

[redacted]

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

Original report signed by the inspector.