Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 28, 2013	2013_159178_0004	T-0025-13/T-1507-12/T-1537-12	Complaint

Licensee/Titulaire de permis

THE JEWISH HOME FOR THE AGED
3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1

Long-Term Care Home/Foyer de soins de longue durée

THE JEWISH HOME FOR THE AGED (2824)
3560 BATHURST STREET, NORTH YORK, ON, M6A-2E1

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

SUSAN LUI (178)

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): February 4,5,6,22,26,27, 2013

During the course of the inspection, the inspector(s) spoke with family of a resident, Director of Care, Apotex 3 Unit Director, registered staff, personal support workers, dietary aide, Manager Food and Nutrition Services.

During the course of the inspection, the inspector(s) observed resident care, reviewed resident records, reviewed home records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

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1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Resident # 1 fell twice during the night on an identified date. The resident was sent to the Xray department in the morning, where it was determined that the resident had fractured his/her right hip.
Staff and family interviews confirm that on return to the resident's room after the Xray, the two personal support workers (PSWs) who had accompanied the resident to the Xray department transferred the resident from stretcher to wheelchair without seeking determination of the resident's mobility needs. During interviews the PSWs reported that the resident was resisting transfer from stretcher to bed and wanted to be in his/her wheelchair.
Registered staff on the unit had been made aware of the resident's fractured hip diagnosis by this time and were aware that the resident should remain in bed or stretcher, but had not yet communicated this information to the PSWs.
[s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in behaviour management annually or according to each staff member's individually assessed training needs, as required in O.Reg 79/10,s.221(2).
Staff interviews and record review confirm that not all the direct care staff working on the Behavioural Support Unit (BSU) on the night of an identified date, had received training in behaviour management within the previous twelve months, or according to their individually assessed training needs. On this night, an altercation occurred between two identified residents, resulting in the serious injury of resident # 1. Out of the four staff members working on the BSU that night, only two had received training in behaviour management within the previous twelve months. The Registered Nurse supervisor who responded to the incident that night, had also not received training in behaviour management within the previous twelve months. [s. 76. (7) 3.]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in behaviour management annually or according to each staff member's individually assessed training needs, as required in O.Reg 79/10,s.221(2), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are available at each meal and snack.

The planned menu items for the pureed menu were not available on Tuesday February 26, 2013 for the lunch meal. Observations and staff interviews confirm that pureed roast beef was not available as per the planned menu for February 26, 2013. The only pureed entrees offered and available for this meal were chicken a la King and boiled chicken. [s. 71. (4)]

Issued on this 20th day of March, 2013

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

Susan Liu (178)