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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_641665_0006	022310-19, 000159-20	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

JOY IERACI (665)

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 11, 12, 13, 15, 18-21, 25, 26 and 28, 2020. Off site interviews March 2, 3, 4 and 10, 2020.

The following complaint intake logs were inspected:
- Log #000159-20 related to plan of care, nail care and prevention of abuse;
- Log #022310-19 related to medication management, plan of care and communication response system.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Pharmacy Manager (PM), Physiotherapist (PT), Unit Managers (UM), Nursing Informatics (NI), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Support Resource Lead (BSRL), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspectors observed staff and resident interactions, reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #004 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Long Term Care (MLTC) received complaints related to numerous care concerns of resident #004.

A) In an interview, the complainant was concerned that the resident was not being turned and repositioned to manage resident #004's altered skin integrity. It was the complainant's understanding that the staff was to turn the resident every two hours from side to side with the aide of a positioning device that was provided to the resident. The complainant had observed the resident on their back and the resident complained of pain to the area of altered skin integrity on two occasions: one in an identified month in 2019, and another on an identified date in 2020.

Review of resident #004's written plan of care, specifically the kardex directed staff to reposition the resident every two hours to offload pressure to an identified area.

Review of the progress notes in Point Click Care (PCC) on an identified date in 2020, by RN #139 showed that the complainant found the resident lying flat on their back and the

resident complained of pain to the area of altered skin integrity. The progress note indicated that the occupational therapist (OT) had recommended that the resident be turned and repositioned every two hours from side to side and on their back. At the time of the complainant's observation, the RN documented that the PSW had just repositioned the resident on their back and the complainant was informed about the OT's recommendation.

In an interview, UM #103 stated that they had a conversation with the complainant to ensure that resident #004 was turned and repositioned every two hours on each side, and the resident will be on their back for meals. The UM indicated they had followed up with staff on the unit to reinforce the importance of turning and repositioning of resident #004 from side to side. The inspector informed the UM that the resident's written plan of care did not specify that the turning and repositioning was from side to side, and the staff were turning and repositioning the resident on their back. UM #103 indicated that there should have been more collaboration between themselves, the registered staff and the PSWs regarding the implementation of resident #004's plan of care related to turning and repositioning.

B) In an interview, the complainant had concerns regarding resident #004's medication management.

A review of the resident's progress notes in PCC and their electronic medication administration record (eMAR) for an identified month in 2020, showed that the resident was diagnosed with an identified condition and was prescribed a specified medication on an identified date in 2020. The eMAR showed the resident received the medication on three identified dates in 2020.

The resident had a follow up assessment by Consulting Physician (CP) #138, four days after the specified medication was prescribed. The CP documented in the progress note of their recommendation to extend the course of the medication for a specified period to treat resident #004's condition. Based on this recommendation, the resident's next dose of the medication was to be scheduled for administration in two days.

Three days after CP #138's assessment, RN #106 documented in the progress notes that the complainant was concerned that the resident did not continue the specified medication as recommended by CP #138. RN #106 documented that they had left a note for the attending physician to review the recommendation on their next visit.

The physician on call assessed the resident and acknowledged the recommendation from CP #138's assessment three days earlier, and prescribed ongoing treatment of the specified medication to treat the resident's identified condition.

In an interview, RN #136 indicated when a consulting physician assesses a resident, it was the home's process for the registered staff to read the progress notes and call the attending physician for any recommendations. The RN stated that there was a gap in the home's process when consulting physicians assesses a resident; since, the registered staff were not always notified or made aware that a consulting physician had assessed a resident. When this occurs, progress notes will not be reviewed to address any recommendations from the consultant's assessment. The RN acknowledged collaboration did not occur between the consulting physician, attending physician and registered staff when CP #138 assessed resident #004 and recommended to extend the resident's medication to treat their identified condition.

In an interview, UM #103 indicated when consultant physicians assesses a resident, it was the home's expectation for the registered staff to review the progress notes and inform the attending physician of any assessed recommendation/s. The evidence above was reviewed with the UM and they stated that the registered staff should have reviewed the assessment from the CP #138 on the day of assessment. Additionally, the registered staff should have notified the attending physician regarding the recommendation to extend the resident's medication on the same day of CP #138's assessment.

This non compliance is issued as the staff and others involved in the different aspects of care of resident #004 failed to collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other. [s. 6. (4) (b)]

2. The licensee has failed to ensure that resident #004's substitute decision-maker, was given an opportunity to participate fully in the development of the resident's plan of care.

The MLTC received complaints from the SDM of resident #004 related to not being notified of changes to the plan of care of the resident. The complainant informed Inspector #558 that they were not notified when the resident's plan of care was changed on an identified date in 2020. The complainant had concerns regarding the safety of the resident as a result of the change in the plan of care.

Review of resident #004's written plan of care 10 days prior to the complainant's concern, showed that two staff were to provide all care for all shifts.

In an interview, RN #141 reviewed the written plan of care for resident #004 and stated that the plan of care was revised on the identified date, by UM #127. The RN indicated that the plan of care now directed two staff members to be present during all interactions for treatments, medications and answering call bells. They reviewed the progress notes in PCC and stated that they did not find documentation that the SDM was notified of the change.

In an interview, UM #127 indicated the home had an interdisciplinary meeting and a decision was made to change resident #004's plan of care to promote their sense of safety. The plan of care was changed to ensure that two staff were to be present for all interactions with the resident. The UM verified they did not notify the SDM of the change.

This non compliance is issued as the licensee failed to ensure that resident #004's SDM, was given an opportunity to participate fully in the development of the resident's plan of care

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 staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and, ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by resident #004 at all times.

The MLTC received complaints related to numerous care concerns of resident #004. In an interview, the complainant indicated there were incidents within a three month period in 2019 and 2020, where the call bell was not accessible to resident #004 while in bed.

During observations conducted on an identified date and time, resident #004's call bell was observed to be on top of their pillow at the head of the bed. PSW #111 was in the room and informed the inspector they adjusted the head of the bed as per the resident's request. When asked where the call bell was, resident #004 stated that it was to be beside them in bed. The PSW adjusted the call bell to ensure it was within reach of the resident.

In an interview, UM #103 stated it was the expectation for staff to ensure call bells are within reach and accessible to residents. The UM was aware of the incident in 2020, and had followed up with staff to ensure the call bell was always accessible to resident #004. The UM acknowledged that the staff did not ensure that the call bell was easily accessed by resident #004 at all times. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, was on at all times.

In an interview, the complainant indicated on an identified date in 2020, the call bell had been dislodged from its socket and not on at all times.

Review of resident #004's progress notes in PCC did not have documentation related to the incident.

In an interview, UM #103 stated they investigated the concern and was informed by staff that the call bell was dislodged from the socket when they had moved the resident's bed when care was provided. The staff did not notice the call bell was dislodged when they left the resident's room. The UM indicated they spoke to the unit staff to ensure the call bell was always attached to its socket and on at all times. The UM acknowledged that the staff did not ensure that the call bell was on at all times.

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 home is equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times; and (b) is on at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The MLTC received a complaint through the ACTIONLine on an identified date in 2020, related to numerous care concerns of resident #004. The complainant had concerns that resident #004's toenails were not being cut regularly.

In an interview, the complainant stated they waited three months for a chiropody appointment in the home to cut resident #004's toe nails.

Record review of an identified assessment dated about a month prior to the complainant's concern, documented that resident #004 had poor foot care with evidence

that nails had not been cared for in several months.

In interviews, PSWs #105 and #104 indicated that nail care was provided to all residents. Both indicated that toenails were cut by chiropody not by the PSWs.

In an interview, UM #103 stated it was the home's process for PSWs to provide nail care on the resident's shower days and it was the responsibility of the registered staff to assess the resident's toenails on shower days as well. The registered staff were to cut the toenails or make a referral for chiropody to cut the toenails. The UM indicated that they received complaints from the complainant regarding nail care for both fingernails and toenails on two identified months in 2019 and 2020.

In the interview, the inspector reviewed with UM #103 the documentation in the identified assessment, indicating that foot care was not cared for in several months. The UM stated that the PSWs and registered staff should have reported to their supervisor the need for resident's #004's toenails to be cut. The UM acknowledged that staff failed to ensure resident #004 received preventive and basic foot care services of cutting toenails. [s. 35. (1)]

2. The licensee has failed to ensure that resident #004 received fingernail care, including the cutting of fingernails.

The MLTC received a complaint through the ACTIONLine on an identified date in 2020, related to numerous care concerns of resident #004. The complainant had concerns that resident #004's fingernails were not being cut regularly.

In an interview, the complainant requested staff to cut resident #004's fingernails but waited three weeks for their fingernails to be cut in an identified month in 2020. The complainant was told by staff that fingernails were cut on resident #004's shower days twice a week.

In interviews, PSWs #105 and #104 indicated that nail care was provided to all residents. Both indicated that they ensure residents' fingernails were clean when care was provided. PSW #105 stated that the cutting of fingernails was done on shower days by the full time PSW assigned to the resident. However, PSW #104 stated that cutting of fingernails was done if the resident requested them to be cut.

Record review of resident #004's documentation survey report at the time of the

inspection indicated that the resident's shower days were on two identified days and shift.

Observations conducted on three separate dates during the inspection, showed resident's fingernails to be the same length and not trimmed on their scheduled shower days.

Interview with resident #004 on an identified shower day, indicated they did not like the length of their fingernails and would like them cut.

In an interview on the resident's identified shower day, PSW #105, indicated they did not cut resident #004's fingernails as it was the full time PSW that was responsible for cutting the resident's fingernails.

In an interview, UM #103 stated it was the home's process for PSWs to provide nail care on the resident's shower days which included cutting of fingernails. The UM indicated that they received complaints from the complainant regarding nail care for both fingernails and toenails on two identified months in 2019 and 2020. The complainant was concerned that resident #004's fingernails were not being cut. The UM followed up with the staff on the unit to ensure the resident's fingernails were cut during their shower days twice a week. The UM sated that resident #004's fingernails should have been cut routinely by staff. They acknowledged that staff failed to ensure resident #004 received fingernail care, including the cutting of fingernails.

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 each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection and fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of resident #004, including assessments.

The MLTC received a complaint through the ACTIONLine on an identified date in 2020, related to the home's management of resident #004's allegations of rough care by staff.

In an interview, the complainant stated that UM #103 informed them that resident #004's allegations of receiving rough care by staff was a responsive behaviour. They indicated that the resident was not diagnosed and assessed of having responsive behaviours by the physicians in the home.

A review of the home's policy titled Responsive Behaviours – Management, created date of July 2018, directed the registered staff to: A) Conduct and document an assessment of the resident experiencing responsive behaviours to include: completing behavioural assessments based on resident need; B) An electronic Responsive Behaviour Referral to the internal Behavioural Support Team (BSO) Lead/Designate is completed when there is a new, worsening, or change in responsive behaviours and; C) Refer to available resources in the care community or healthcare community resource such as Behavioural Support Team or Behavioural Intervention Response Team if available, or other similar type community team e.g. Psychogeriatric Resource Team and/or Psychogeriatric Resource Consultant and RN (EC).

In an interview, BSRL #116 indicated that when a resident has responsive behaviour, the

physician would assess the resident and would officially diagnose the resident with a specified diagnosis and document in the resident's file as required. They confirmed they had not received a referral to assess resident #004 for responsive behaviours within the past year and half or two years.

Review of the resident's medical diagnosis in PCC indicated that the resident had an identified diagnosis. However, the medical diagnosis in PCC did not include a diagnosis of responsive behaviour or the specified diagnosis noted above. The resident had an identified assessment on an identified date in 2019, where a specified examination was performed. The identified assessment documented it focused on a medication review. The assessment did not have documentation related to the resident's allegations of rough care by staff as a responsive behaviour nor a diagnosis of the specified diagnosis. Further review of resident #004's clinical records did not show documentation of a responsive behaviour assessment.

In an interview, UM #103 stated that when a resident has responsive behaviour, the resident was assessed by the interprofessional team and a referral was made to BSRL #116 for an assessment. They indicated that the home assessed resident #004's allegations of rough care by staff as a responsive behaviour in an identified month in 2020. The UM confirmed that BSRL #116 was not involved in the assessment, and a referral to them was not made as per the home's process. On an identified date in 2020, the UM, DOC #101 and Physician #137 discussed the resident's responsive behaviour, but a diagnosis of responsive behaviour or the specified diagnosis was not in the resident's clinical records.

This non compliance is issued as the home failed to ensure that for each resident demonstrating responsive behaviours, actions was taken to respond to the needs of resident #004, including assessments.

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 for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #004 in accordance with the directions for use specified by the prescriber.

The MLTC received complaints related to numerous care concerns of resident #004. In an interview, the complainant informed the inspector of a medication incident that occurred on three consecutive days in 2020. The resident was to receive an identified medication and dose, but received double the dosage for three days.

On an identified date in 2020, an identified consult was conducted by CP #138. In the consult note, the physician recommended resident #004 to start their scheduled identified medication and dose mentioned above.

Review of the physician orders in PCC showed that one day after the identified consult, Physician (PHY) #137 prescribed the identified medication at specified times a day. The physician orders also showed an order on an identified date in 2019 for the same medication to be administered at different times of the day.

Review of resident #004's eMAR at the time of the medication incident, included the two medication orders from 2019 and 2020, for administration to the resident. Both medication orders were administered to the resident for three consecutive days which resulted in the resident receiving double the prescribed dose.

Review of the home's medication incident report documented the incident was a pharmacy related error.

In an interview, PM #109 indicated they were aware of the medication incident involving resident #004's identified medication. When the pharmacy received the medication order on the identified date in 2020, it appeared to be an increase to the resident's existing medication order. The total dose of both the medication orders were still within the therapeutic range of the medication. The medication incident was being reviewed for root causes at the time of the inspection and the PM indicated that the pharmacy takes responsibility for not clarifying with the physician the medication order on the identified date in 2020.

In an interview, UM #103 indicated the medication incident was pharmacy related, as the pharmacy did not clarify the medication order on the identified date in 2020.

This non compliance is issued as the home failed to ensure that drugs were administered to resident #004 in accordance with the directions for use specified by the prescriber.

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of June, 2020

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

Original report signed by the inspector.