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
Dec 22, 2021	2021_833763_0025	011925-21, 011926-21, 015935-21	Critical Incident System

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

IANA MOLOGUINA (763), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 29, December 1, 3, 6, and 7, 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

- Log #015935-21, CIS #2824-000060-21 was related to an unexpected death,
- Log #011926-21 was a follow-up to compliance order (CO) #001 from inspection #2021_650565_0008 regarding s. 19. (1) with a compliance due date (CDD) of October 8, 2021; and
- Log #011925-21 was a follow-up to CO #001 from inspection #2021_650565_0006 regarding r. 131. (2) with a CDD of October 8, 2021.

During the course of the inspection, the inspector(s) spoke with the interim Executive Administrator (ED), assistant to the ED, interim Director of Care (DOC), Infection Prevention and Control (IPAC) practitioner, Registered Dietitian (RD), Food Service Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #001	2021_650565_0006	565
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_650565_0008	565

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment when they left a fridge unlocked and accessible to a resident.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) regarding an unexpected death. The report indicated that prior to finding the resident unresponsive, staff saw them looking for food items at the nursing station. The cause of death was choking.

Record review and staff interviews indicated that the resident had responsive behaviours that escalated when confronted by staff. The resident often took food and fluids from the nourishment fridge located at the nursing station, containing food and fluid items of all textures and consistencies.

They were receiving a modified texture diet at the time of their death. Staff, including the dietitian involved in the resident’s care at the time, were aware of the resident’s behaviours and did not implement strategies to limit their unmonitored access to the nursing fridge as they believed this would further increase behavioural issues and be difficult for staff to manage.

Inspector #763 observed several nursing fridges throughout the home and interviewed several staff about the home’s practices. Staff indicated that most units in the home did not lock their nourishment fridges and that the nursing station was not always monitored by staff. The home’s interim ED and FSM indicated that leaving the fridges unlocked increased the risk of residents accessing food and fluids while unsupervised, presenting a choking risk.

Sources: resident's clinical records (care plan, progress notes, assessments, risk management assessments, PointClickCare profile); CIS #2824-000060-21, staff interviews (RPN #110, RD #111, interim ED #100, FSM #115, and other staff). [s. 5.]

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 in ensuring the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Findings/Faits saillants :

1. The licensee has failed to immediately inform the Director of the unexpected or sudden death of a resident.

A CIS report was submitted in 2021, to the MLTC regarding the unexpected death of the resident in 2019.

Record review and staff interviews confirmed that the home submitted the CIS report two years after the incident and only submitted it in 2021 when they realized the error.

Sources: resident's clinical records (care plan, progress notes, assessments, risk management assessments, PointClickCare profile); CIS # 2824-000060-21, staff interviews (interim ED #100). [s. 107. (1) 2.]

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 in ensuring the Director is informed immediately of any incidents involving an unexpected or sudden death, to be implemented voluntarily.

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.