Ontario

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

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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
May 13, 2014	2014_102116_0018	T-495-14	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

SARAN DANIEL-DODD (116)

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): May 1, 2, 5, 6, 7, 9, 2014.

During the course of the inspection, the inspector(s) spoke with Executive Director, Interim Director(s) of Care, Unit Directors, resident #1, family members, registered staff, personal support workers (PSW), social worker, hairdresser, and communications staff.

During the course of the inspection, the inspector(s) reviewed the health record of resident#1, observed staff to resident interactions and the following home policies and procedures: abuse and neglect of clients:zero tolerance, clients rights and responsibilities, clients complaints process, follow up for client/family compliments and complaints, Baycrest privacy code and guidelines for clinical treatment during the Jewish holy days and the Sabbath.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Reporting and Complaints

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.) 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Interview held with a member of the management team on a specified date, confirmed being made aware of assertions of neglect regarding care needs of resident#1 and negative interactions between staff and resident #1 over a specified period. As per the member of the management team, the information upon which the suspicions of neglect were made were not reported to the Director [s. 24. (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 to ensure that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #1 was afforded privacy in treatment and in caring for his/her personal needs.

- Resident #1's plan of care identifies the resident's request for the room's door to remain closed and for all staff to knock on the door before entering. The resident's plan of care also documents the resident requests to only be changed by female staff. During the inspection it was observed that there is a sign posted on the outside of the door alerting staff of the request.
- A review of the resident's health record and interviews held with registered staff and PSWs confirmed that on a specified date, an identified PSW was attending to the care needs of resident #1 with the door partially open. The resident indicated that his/her reflection is visible from the window in front of the bed. Subsequently, on another occasion, a male PSW opened the resident's door unannounced while conducting rounds during the shift.
- On a specified date during the inspection, the inspector observed an identified staff member open the resident's room door unannounced. The staff member did not announce the entry or knock on the door. [s. 3. (1) 8.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident where the complaint alleges harm or risk of harm to one or more residents an investigation was not commenced immediately.

Interview held with a member of the management team confirmed that verbal complaints made on behalf of resident #1 regarding negative interactions with staff and personal care not being provided for long durations of time during a specified period were not investigated immediately after being brought to the management team's attention by family members of resident #1. [s. 101. (1) 1.]

Issued on this 13th day of May, 2014

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

S. Daniel-Dodd