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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 18, 2019	2018_766500_0018 (A1) (Appeal\Dir#: DR# 107)	026782-18, 027075-18	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 Pamela Chou (Director) - (A1)(Appeal\Dir#: DR# 107)

Amended Inspection Summary/Résumé de l'inspection modifié

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#001.
The Director's review was completed on January 18, 2019.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 107.
A copy of the Director Order is attached.

Issued on this 18th day of January, 2019 (A1)(Appeal\Dir#: DR# 107)

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

Original report signed by the inspector.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by Pamela Chou (Director) - (A1)(Appeal/Dir# DR# 107)

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): October 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 29, 2018.

The sample expansion of all non-compliance identified during this inspection were inspected during Critical Incident System (CIS) inspection #2018_530726_0007, intakes log #011663-18, and #022385-18 by inspector #726.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Unit Manager, Chaplin, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Resident.

During the course of the inspection, the inspector observed the resident care areas, reviewed resident health care records, staffing schedules, and home's policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #001 that sets out, clear directions to staff and others who provide direct care to the resident.

An interview with the complainant and a review of the complaint received by Ministry of Health and Long-term care (MOHLTC), indicated that resident #001 reported that they were treated in an inappropriate manner by a Personal Support Worker (PSW) during the provision of care on an identified day. During the provision of personal care, when resident #001 requested the PSW to provide care properly, the PSW acted inappropriately and made an inappropriate comment. This caused the resident both physical as well as emotional distress. The resident was upset because of the incident. The resident was totally competent and aware of the resident's rights.

A review of the Critical Incident System (CIS) submitted on an identified date to the MOHLTC, indicated that while receiving care from two staff members, the resident stated that one of the PSWs used force while providing personal care. A review of Minimum Data Sheet (MDS) indicated that the resident required total care from two people for personal care.

A review of the resident's written plan of care indicated that the resident required total assistance from two staff for personal care. The resident chose and refused staff members for care. The resident demonstrated some inappropriate expressions to the staff members due to agitation. Staff were required to prevent escalation of agitation by not getting into an argument, and to leave the resident's room and return later.

A review of clinical records and the resident's plan of care did not indicate the resident's inappropriate requests during personal care and interventions to address this requests.
Interview with resident #001 indicated that if the resident does not feel that the proper care was provided, they make requests to staff to repeat the care. The resident indicated that they are very specific and direct their own care and explain to the staff member the way the resident would prefer the staff to provide care.

A review of the resident's kardex did not indicate how direct care staff are required to provide personal care to the resident.

Interview with PSW #108 indicated that the resident always asked them to provide personal care in an inappropriate manner. PSW #108 indicated that if they are not feeling comfortable, and if they don't provide care as requested by the resident, the resident would become upset towards the staff member. PSW #108 indicated that they would use a towel and provide personal care to the resident as per the resident's request. PSW #108 indicated that if they do it, it could be socially inappropriate and feel scared and stressed because of the inappropriate requests from the resident during personal care. PSW #108 indicated that the resident has started making requests over the past six- seven months. The PSW #108 indicated having some conversations about this with management and nothing has been done by the management, the only thing the management suggested, is that they leave the resident's room when the resident starts becoming upset and return to the resident in five-10 minutes to provide care.

PSW #103 indicated that the resident would not be satisfied with the care, and would make an inappropriate request while receiving personal care. If the staff does not provide care as per the resident's request, the resident will become upset to the staff member. PSW #103 indicated the resident makes inappropriate requests to the regular PSWs while receiving personal care, and staff have to do it. PSW #103 indicated that it is out of their scope of practice.

Interviews with PSW #102 indicated that the resident is requesting staff to repeat personal care, and providing care as per the resident's requests is out of their scope of practice. The resident would make staff repeat personal care.

Interview with RPN #104 indicated that the resident would ask PSWs to provide care in an appropriate manner and hold the PSWs hand and force staff to provide care the way the resident wants. If they don't, the resident will have a problem. RPN #104 indicated that PSWs learn about how to provide care to resident in their school and to address the resident's requests is out of their scope of practice.

Interview with RN #105 indicated that the resident would ask staff to repeat and to provide the personal care in an inappropriate manner. There were two staff that reported they did not feel comfortable providing care to the resident.

Interview with Chaplin #106 indicated that, the PSWs are not allowed to provide care in a manner which is out of their scope of practice. If the resident is

demanding for the care which cannot be provided by the staff, there should be an assessment completed and clear interventions developed in order to address the resident's inappropriate request. Staff should know what care to be given, and what answer to be given to the resident.

Interview with Unit Manager #101 indicated that the PSWs are not allowed to provide care in an inappropriate manner. The doctor had a conversation with the resident about the personal care and the resident indicated that they require to feel clean, and the resident still continues to make inappropriate requests to staff while receiving personal care. Unit Manager #101 indicated that staff complained about providing care to the resident, however there was no formal assessment completed for the resident. Unit Manager #101 indicated that staff should have clear direction about the resident's plan of care and are expected to implement it.

During an interview with the Executive Director (ED), they indicated that the home is having challenges due to staff concerns about providing care to the resident.

On the basis of the following, the inspector warranted this non-compliance:
- a lack of a clear direction for staff to provide identified care to the resident,
- the written plan of care not including appropriate interventions in order to address the resident's inappropriate request during personal care, and
-staff having inconsistent approach handling the resident's request while personal care resulted into inconsistent care to the residents and increased conflicts between the
resident and staff during a period of time. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

An interview with the complainant and a review of the complaint received by Ministry of Health and Long-term care (MOHLTC), indicated that resident #001 reported that they were treated in an inappropriate manner by a Personal Support Worker (PSW) during the provision of care on an identified day. During the provision of personal care, when resident #001 requested the PSW to provide care properly, the PSW acted inappropriately and made an inappropriate comment. This caused the resident both physical as well as emotional distress. The resident was upset because of the incident. The resident was totally competent and aware of the resident's rights.

A review of the Critical Incident System (CIS) submitted on an identified date to the MOHLTC, indicated that while receiving care from two staff members, the resident stated that one of the PSWs used force while providing personal care.

A review of Minimum Data Sheet (MDS) indicated that the resident required total care from two people for personal care.

A review of the resident's written plan of care indicated that the resident required total assistance from two staff for personal care. The resident chose and refused staff members for care. The resident demonstrated some inappropriate expressions to the staff members due to agitation. Staff were required to prevent escalation of agitation by not getting into an argument, and to leave the resident's room and return later.

A review of clinical records and the resident's plan of care did not indicate the resident's inappropriate requests during personal care and interventions to address this requests.

Interview with resident #001 indicated that if the resident does not feel that the proper care was provided, they make requests to staff to repeat the care. The resident indicated that they are very specific and direct their own care and explain to the staff member the way the resident would prefer the staff to provide care.

A review of the resident's clinical record indicated no specific assessment completed in order to address the resident's specific request for staff to provide personal care. A review of clinical records and the resident's plan of care did not indicate the resident's requests for staff during personal care and interventions to address this request.

Interview with PSW #108 indicated that the resident always asked them to provide personal care in an inappropriate manner. PSW #108 indicated that if they are not feeling comfortable, and if they don't provide care as requested by the resident, the resident would become upset to the staff member. PSW #108 indicated that they would use a towel and provide personal care to the resident as per the resident's inappropriate request. PSW #108 indicated that if they do it, it could be socially inappropriate and feel scared and stressed because of the inappropriate requests from the resident during personal care. PSW #108 indicated that the resident has started making requests over the past six-seven months. The PSW

#108 indicated having some conversations about this with management and nothing has been done by the management, the only thing the management suggested, is that they leave the resident's room when the resident starts becoming upset and return to the resident in five-10 minutes to provide care.

PSW #103 indicated that the resident would not be satisfied with the care, and would make an inappropriate request while receiving personal care. If the staff does not provide care as per the resident's request, the resident will become upset towards the staff member. PSW #103 indicated the resident makes inappropriate requests to the regular PSWs while receiving personal care, and staff have to do it. PSW #103 indicated that it is out of their scope of practice.

Interviews with PSW #102 indicated that the resident is requesting staff to repeat personal care, and providing care as per the resident's requests is out of their scope of practice. The resident would make staff repeat personal care.

Interview with RPN #104 indicated that the resident would make inappropriate requests to PSWs while receiving personal care. If they don't provide care in a manner the resident requested, the resident will have a problem. RPN #104 indicated that PSWs learn about how to provide care to resident in their school and are not allowed to go beyond their scope of practice. RPN #104 indicated that there should have been an assessment completed for the resident.

Interview with RN #105 indicated that the resident would ask staff to repeat and to provide the personal care in an inappropriate manner. There were two staff that reported they did not feel comfortable providing care to the resident. RN #105 indicated that there should have been an assessment.

Interview with Chaplin #106 indicated that, the PSWs are not allowed to provide care in a manner which is out of their scope of practice. If the resident is demanding for the care which cannot be provided by the staff, there should be an assessment completed and clear interventions developed in order to address the resident's inappropriate request. Staff should know what care to be given, and what answer to be given to the resident.

Interview with Unit Manager #101 indicated that the PSWs are not allowed to provide care in an inappropriate manner. The doctor had a conversation with the resident about the personal care and the resident indicated that they required to feel clean, and the resident still continues to make inappropriate requests to staff

while receiving personal care. Unit Manager #101 indicated that staff complained about providing care to the resident, however there was no formal assessment completed for the resident.

During an interview with the ED, they indicated that the home is having challenges due to staff concerns about providing care to the resident.

On the basis of the following, the inspector warranted this non-compliance:
-a lack of assessment to develop appropriate interventions to identify the resident's needs in order to address the resident's request during care,
-staff having inconsistent approach handling the resident's request during care resulted into inconsistent care to the residents and increased conflicts between the resident and staff during a period of time. [s. 6. (2)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 107)
The following order(s) have been rescinded: CO# 001

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully

respected and promoted: every resident has the right to be treated with courtesy and
respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

An interview with the complainant and a review of the complaint received by MOHLTC, indicated that resident #001 reported that they were treated in an inappropriate manner
by a PSW during the provision of care on an identified day. During the provision of personal care, when resident #001 requested the PSW to provide care properly, the PSW acted inappropriately and made an inappropriate comment. This caused the resident both physical as well as emotional distress. The resident was upset because of the incident. The resident was totally competent and aware of the resident's rights.

A review of the CIS submitted on an identified date to the MOHLTC, indicated that while receiving care from two staff members, the resident stated that one of the PSWs used force while providing personal care.

A review of MDS indicated that the resident required total care from two people for personal care.

A review of the resident's written plan of care indicated that the resident required total assistance from two staff for personal care. The resident chose and refused staff members for a care. The resident demonstrate some inappropriate expressions to the staff members due to agitation. Staff were required to prevent escalation of agitation by not getting into an argument, and to leave the resident's room and return later.

A review of clinical records and the resident's plan of care did not indicate the resident's inappropriate requests during personal care and interventions to address this requests.
An interview with the resident and a review of an email sent by the resident to the complainant indicated that PSW #102 made an inappropriate comment indicating "do it by yourself" when the resident requested them to apply ointment during the personal care. The PSW #102 also used too much water, when the resident asked the PSW to wash with extra water during care. They stated that it felt like the PSW dumped a bucket of water on the resident. The resident reported that PSW #102 made inappropriate comments and applied force while providing

personal care. The resident felt shocked and hurt. Resident said PSW #102 mocked them with an inappropriate comment when the resident told them that they will report the PSW. The resident confirmed that PSW #103 was present while the incident occurred. The resident indicated feeling that PSW violated the resident's rights.

During an interview, PSW #102 indicated that the resident is cognitively intact and required care in a particular way. PSW #102 indicated that during care, the resident requested for a lot of water, wipes, towel and all the resident's demands were fulfilled. PSW #102 denied making any inappropriate comments and applying force while providing personal care to the resident. The PSW however confirmed saying they were in "good company", with the resident. The PSW also denied using a lot of water to wash the resident or mocking the resident.
Interview with PSW #103 who worked as a floater on the day, when the above incident
occurred.

PSW #103 indicted that on an identified day, PSW #103 and PSW #102 went to the resident's room for care. The resident was sleeping and asked them to return in half an hour. PSW #102 was upset because of this. During care, PSW #102 did not use a lot of water, however the resident felt like it was too much water. The resident might have felt rough care, however they did not see PSW #102 applying force while providing care to the resident. PSW #103 confirmed that during personal care, PSW #102 was upset, and their behaviour was not polite and respectful to the resident. PSW #102 made inappropriate comments to the resident, when the resident requested to apply ointment in a loud voice. Further to this, PSW #103 stated that PSW #102 mocked the resident when the resident threatened to report PSW #102.

Interview with Registered Staff (RN) #107, indicated that the resident was upset with the staff, however, the above-mentioned incident was not reported by the staff who provided
the care to the resident. Interview with RPN #104 indicated that on an identified day, the resident shared their experience of the incident and indicated that the resident is cognitively alert and can express themselves. The resident was crying and reported to them about the incident, and how the staff dumped lot of water on them, and made an inappropriate comment.

Interview with RN #105 confirmed that the resident is well aware of what is going

on around them. The resident was crying and was in emotional stress while sharing their experience of the incident. The resident indicated that they were physically hurt because the PSW's action.

Interview with Chaplin #106 indicated that the resident is cognitively aware and alert. While talking about the incident, the resident was upset, angry and in emotional stress during the conversation about the incident. The resident indicated staff having an angry attitude towards the resident and identified a couple of actions from staff which can be considered abuse. The resident indicated that staff poured water on top of the resident, used a wipe and applied force with an inappropriate comment. The Chaplin identified the resident as having a lot of issues with staff, which are not addressed and at the same time, staff are having issues dealing with the resident.

A review of the home's policy entitled, "Resident Abuse and Neglect: Zero Tolerance", Revised May 2017, indicated that the home is committed to providing a safe care environment for residents that respects and enhances their dignity, security, safety and comfort while meeting their physical, social, spiritual and cultural needs. The residents of the home have a right to be free from all acts of violence, exploitation, intimidation, humiliation, and neglect that could threaten their physical or mental well-being.

Interview with Unit Manager #101 indicated that the resident called them on an identified day, and left a voicemail requesting for a meeting. The resident is cognitively well and can communicate their needs. The resident reported that staff member provided care in an inappropriate manner and made an inappropriate comment while providing personal care. The home identified the allegation of abuse was unsubstantiated during the investigation, however based on the PSW #103 who was present at the same time when the incident occurred, confirmed that PSW #102 put a lot of water on the resident during care, and made a comment to the resident, which is against the code of conduct of the home and disciplinary measures were taken.

A review of the home's employee code of conduct indicated that the home is committed to providing an environment that promotes respects and dignity of all individuals.

Interview with ED indicated that the resident's allegation about abuse were not substantiated based on the home's investigation and indicated that the home is

having challenges due to staff concerns about providing care to the resident.

Based on the resident's consistent statements to multiple people and staff interviews the inspector identified that PSW #102 was upset, and demonstrated disrespectful behaviour
to the resident. The inspector warranted this non-compliance because PSW #102 made inappropriate comments in a loud voice when the resident requested to apply ointment,
mocked the resident with an inappropriate comment when the resident threatened to report PSW #102. [s. 3. (1) 1.]

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 following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure without in any way restricting the generality of

the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

An interview with the complainant and a review of the complaint received by MOHLTC, indicated that resident #001 reported that they were treated in an inappropriate manner by a PSW during the provision of care on an identified day. During the provision of personal care, when resident #001 requested the PSW to provide care properly, the PSW acted inappropriately and made an inappropriate comment. This caused the resident both physical as well as emotional distress. The resident was upset because of the incident. The resident was totally competent and aware of the resident's rights.

A review of the CIS submitted on an identified date to the MOHLTC, indicated that while receiving care from two staff members, the resident stated that one of the PSWs used force while providing personal care. The resident indicated that PSW #103, who witnessed the incident, never reported the incident to the nurse or never went to the get help, did not do anything and just feeling guilty.

A review of the home's policy titled "Resident Abuse and Neglect: Zero Tolerance", revised May 2017, indicated that, residents have the right to be free from all acts of violence, exploitation, intimidation, humiliation, and neglect that could threaten their physical, or mental wellbeing. Abuse and neglect will not be tolerated in the home and it is mandatory to report all incidents of alleged abuse and neglect. The policy indicated that staff must immediately report the suspicion and the information upon which it is based to the unit director or director of care. Failure to report incidents of any kind, which could be construed as abuse, also constitute and offense under the Long-term care Home Act (LTCHA).

Interview with PSW #103 who worked as a floater, when the above incident occurred, indicated that, PSW #103 and PSW #102 went to the resident's room for care, the resident was sleeping and asked them to return in half an hour. PSW #102 was upset because of this. During care, PSW #102 did not use lot of water, however the resident felt like it was too much water. The resident might have felt rough care, however they did not see PSW #102 applying force to the resident during care. PSW #103 confirmed that during personal care, PSW #102 was upset, and their behaviour was not polite and respectful to the resident. PSW #102 made an inappropriate comment, when the resident requested to apply ointment in a loud voice. Further to this, PSW #103 stated that PSW #102

mocked the resident and made another inappropriate comment to the resident, when the resident threatened to report PSW #102. PSW #103 confirmed making a mistake that they should have informed the nurse or call the nurse immediately. They failed to report because, when PSW #103 came out of the resident's room, PSW #102 and RN #107 were talking and they assumed that PSW #102 already reported the incident to the RN.

Interview with RN #107, indicated that the resident was upset with the staff on the day when the incident occurred, however, the above mentioned incident was not reported by the staff who provided the care to the resident.

Interview with RN #105 and Chaplin #106 indicated that the incident should have been immediately reported to the management. Interview with the ED indicated that the staff are expected to immediately report any kind of abuse to the management and the management is responsible to submit a CIS report to the MOHLTC. [s. 20. (1)]

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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 18th day of January, 2019 (A1)(Appeal/Dir# DR# 107)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Pamela Chou (Director) - (A1) (Appeal/Dir# DR# 107)
Inspection No. / No de l'inspection :	2018_766500_0018 (A1)(Appeal/Dir# DR# 107)
Appeal/Dir# / Appel/Dir#:	DR# 107 (A1)
Log No. / No de registre :	026782-18, 027075-18 (A1)(Appeal/Dir# DR# 107)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 18, 2019(A1)(Appeal/Dir# DR# 107)
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Derrick Bernardo

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

(A1)(Appeal/Dir# DR# 107)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of January, 2019 (A1)(Appeal/Dir# DR# 107)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by Pamela Chou (Director) - (A1) (Appeal/Dir# DR# 107)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Toronto Service Area Office