Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Public Copy/Copie 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
Oct 10, 2019	2019_817652_0019	013985-19, 016370-19, 017044-19, 017177-19	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

NATALIE MOLIN (652)

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): September 9, 11, 12, 13, 16,17, 19, 20, 24, 25, 2019. Off-Site September 30, and October 1, 2, 2019.

The following complaint inspections were conducted:

Log #016370-19 related to Nutrition and Hydration
Log # 017044-19 related to Prevention of Abuse and Neglect.
Log # 013985-19 related to Prevention of Abuse and Neglect.

The following critical incident system (CIS) inspection was conducted concurrently with the complaint inspection:

Log #0171779, related to Prevention of Abuse and Neglect.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), nurse managers (NM), registered nursing staff, personal support workers (PSWs), registered dietitian (RD), food and nutrition services manager (FNSM), dietary aide, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of the home; observed staff to resident interactions and the provision of care, reviewed the home's investigations, conducted records review and staff interviews.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint through the Action-line on an identified date. This complaint indicated that during resident #002's stay with the home, they had sustained two episodes of an identified diagnosis that required a hospital admission and then returned to the home. This complaint also indicated on an identified date, resident #002 should have received an identified diet as per discharge records and those orders were not implemented by the home. During an identified time, resident #002 experienced the same symptoms and ultimately died from an identified diagnosis. The complainant reported that during an identified visit they noted that resident #002 was receiving an identified diet and when they questioned the dietary staff it was identified as per the hospital's discharge records that the texture change had not been implemented. In hindsight the complainant reported that after each identified meal time time during visits, they constantly asked why resident #002 was experiencing identified symptoms.

Record review of resident #002's healthcare records indicated the following dietary history:
- A referral form on an identified date, for resident #002 to be assessed by an external consultant related to identified symptoms. Resident #002 was on an identified diet type.The low risk indicators of an identified diagnosis checked on this form indicated identified symptoms.

- A physician's discharge summary from an identified hospital on an identified date, indicated resident #002's most responsible diagnosis. This report also indicated resident #002 was seen by an identified specialist who recommended an identified diet type and an identified diet texture was not allowed. This summary also indicated resident #002 was also at another identified hospital on an identified date for a similar identified diagnosis and was put on an identified medication at that time. It also went on to mention resident # 002 was on an identified food texture and had a history of an identified diagnosis.

- A report from an identified hospital on an identified date at an identified time, stated "resident #002 had a suspected un-witnessed medical event in their home on an identified date and were found to be experiencing identified symptoms.The discharged summary of this report instructed resident #002 to resume an identified diet type at the home and be reassessed by the physician if they developed identified symptoms, or any other symptoms that concerns them or the staff. Items for Follow-Up after Discharge addressed to the home indicated " Please change diet orders to an identified diet type. "

Record review of resident #002's patient care notes by RN #118 on an identified date and time indicated resident #002 returned from an identified hospital at an identified time with an identified discharged diagnosis and that resident was seen by an identified specialist who recommended an identified diet due to high risk of an identified diagnosis. This note also indicated the attending medical doctor was notified and resident #002 was seen by the attending physician who also held conversations with the family.

Record review of resident #002's patient care notes at an identified date and at an identified time by the attending physician, indicated readmission from hospital: called by nurse to report that resident arrived from hospital at an identified time returned to unit to reassess resident, family members at bedside, full discharge summary not available, from admission notes, resident was found to be experiencing identified symptoms at the time of admission, suspected identified diagnoses and required identified medical interventions. Prognosis initially thought to be very poor condition, improved slightly over the course of admission after discussions with family, decision was made to change focus to an identified level of care and repatriate resident to the home.

Record review of resident #002's patient care notes on an identified date and time, by former registered dietitian indicated resident #002 returned to the unit, with identified symptoms and suspected diagnoses. Resume an identified diet type, continue to monitor.

On another identified date former RD indicated resident #002 was on this same diet type.

Record review of resident #002's identified assessment on an identified date, by the former RD indicated resident #002's identified diet type and texture, best consumed meal, location for dining, oral and clinical deficits and assistance required during meals. There was no evidence in this assessment that resident #002's re-admissions diet order from an identified hospital to switch resident to an identified diet type and texture was implemented at the nursing home.

Record review of resident #002's identified medical reports for an identified period both indicated resident #002 was on an identified diet type and texture and, was started on an identified date.

Record review of resident #002's progress notes on an identified date by the attending physician indicated resident #002 showed identified symptoms and suspected an identified diagnosis and as per family, the medical doctor at an identified hospital had told the family that resident #002's diet was recommended to be downgraded to an identified texture after previous admission. This note also indicated the attending physician spoke to the home's registered dietitian who informed them that no documentation regarding downgrading resident #002's diet was sent with the resident after previous hospitalization. Resident was transferred to hospital due to worsened health status and passed away in hospital. No evidence of the cause of death was present on resident #002's chart.

Record review of resident #002's Medical Certificate of Death Form 16, on an identified date, provided to inspector by family member #116 confirmed resident #002's cause of death.

In an interview with family member #116 they indicated resident #002 was discharged from an identified hospital on an identified date, and there were two notes that said resident #002's diet needed to be changed to an identified diet type and texture because, that was the third time resident #002 had an identified diagnosis. Family member #116 indicated the only reason they found out resident #002 was receiving the wrong diet, is when they visited the home, they found identified items on resident #002's plate; they were cut up large pieces and they made the kitchen staff aware that it was the wrong diet, and the kitchen staff said that resident #002 was on an identified diet. Family member #116 said, "no one had changed the notes in the computer when resident #002 returned on an identified date, from the hospital with recommendation to be put on an

identified diet."

In an interview with dietary aide #100 they acknowledged that they remembered resident #002 was on an identified diet and their family member #116 approached them that resident #002 should have been on an identified modified diet and that's when they checked the black book (diet list) and it had an identified diet for resident #002. Dietary aide #100 indicated they were not aware that resident #002 should have been on an identified diet prior to the family bringing forth the concern, and they did not communicate with the nurse on the unit at the time that the family members had concerns regarding resident #002's diet type. They also went on to say they thought the registered dietitian was aware and did not communicate this to their manager or the dietitian until three days after the incident. Dietary Aide #100 indicated if such a situation should re-occur they would call the manager to handle the case.

In an interview with Registered Dietitian (RD) #114, they confirmed that resident #002's diet order had not been changed to an identified diet type and the discharged summary from an identified hospital did indicate to start resident on an identified diet type. Registered Dietitian #114 also indicated the dietitian's scope of practice allows them to write a dietary order and they do not have to wait for the physician to get an order. RD #114 and RN #118 also indicated the home does not utilize a formal process for implementing dietary referrals and referrals to the RDs can be in the form of voice messages, emails and verbally when on the units. There was no evidence to support a referral had been sent to former dietitian #119 on an identified date, when the hospital recommended resident #002's diet to be changed from one diet type to another. RD #119's documentation on an identified date, indicated staff to resume an identified diet for resident #002.

Former registered dietitian #119 responsible for resident #002's assessments and follow-up had retired from the home at the time of this inspection. Inspector attempted to contact this dietitian however their voice messaging system indicated that they were unable to receive calls.

Inspector was unable to interview attending physician due to the fact that they were on leave at the time of the inspection.

DOC #113 and ED #114 were made aware by the inspector of the non-compliance identified during this inspection.

There was no evidence to support during this inspection that resident #002's diet had been changed to an identified diet type and texture based on the last recommendations from the hospital when resident #002 was readmitted to the home on an identified date.

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint through the Action-line on an identified date related to the prevention of abuse and neglect.

MLTC received a critical incident system (CIS) report on an identified date and time. This CIS indicated on an identified date, resident # 001 reported that PSW #102 pushed resident #001 during care while assisting to turn resident #001 in bed. Resident #001 claimed an identified body part hit the wall.

Record review of resident #001's progress notes on an identified date indicated resident #001 reported to RPN #107 that PSW #102 was rough with them during care.

Record review of resident #001's identified assessment on an identified date , indicated they had two identified injuries on an identified body measuring 1 cm x 1.5 cm (both same size).

In an interview resident #001's family member #115 confirmed that resident #001 reported to them that on an identified date and on an identified shift,PSW #102 was abusive to them and resident #001 was very upset and they sustained injury to an identified body part. Family member #115 also indicated they visited resident #001 the next day on an identified date, and, saw injury to resident #001's identified body part. Family member #115 indicated resident #001 was supposed to have two staff members provide care and PSW #102 did not follow resident #001's plan of care.

In an interview resident #001 indicated that they were pushed and rough handled by PSW #102 during care and two people were required to provide care however PSW #102 provided care on their own when this incident occurred.

In an interview PSW #102 indicated that on the night of the incident they were informed by RPN #107 that resident #001 required two people to provide care for them. PSW #102 was directed by RPN #007 to not provide care to resident #001 on their own. PSW #102 said, " I accept that it was my fault, I went alone."

In an interview RPN #107 indicated that they were not there and said, "that night, I made it clear to PSW #102 and said, "I spoke to them adamantly not to provide care alone; call me or wait until I get back."

In an interview RN #103 indicated they received a report from RPN #107 that when RPN #107 went to see resident #001 they indicated that PSW #102 was rough with them during care and resident #001 required two people for care.

In an interview unit manager #110 acknowledged from their understanding upon the home's investigations that PSW #102 did not follow the plan of care for resident #001.

DOC #113 and ED #114 were made aware by the inspector of the non-compliance during this inspection.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and by the licensee or staff in the home.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 "Physical abuse"means: a) the use of physical force by anyone other than a resident that causes physical injury or pain.

The Ministry of Long-Term Care (MLTC) received a complaint through the Action-line on

an identified date related to the prevention of abuse and neglect.

MLTC received a critical incident system (CIS) report on an identified date and time.This CIS indicated on an identified date, resident #001 reported that PSW #102 pushed resident #001 during care while assisting to turn resident in bed. Resident #001 claimed an identified body part hit the wall.

During observations of resident #001, there was no evidence of injury to resident #001's identified body part and no concerns noted regarding staff to resident interactions at the time of the inspections.

Record review of resident #001's progress notes on an identified date, indicated resident #001 reported to RPN #107 that PSW #102 was rough with them during care.

Record review of resident #001's identified assessment on an identified dated, indicated they had two identified injuries noted on an identified body part; measuring 1 cm x 1.5 cm (both same size).

In an interview resident #001's family member #115 confirmed that resident #001 reported to them that on an identified date and on an identified shift; PSW #102 was abusive to them and resident #001 was very upset they sustained injury to an identified body part.Family member #015 also indicated they visited resident #001 the next day on an identified date, and, saw injury to resident #001's identified body part.

In an interview resident #001 indicated that they were pushed and rough handled by PSW #102 during care. Resident #001 also indicated PSW #102 took their identified body part and pushed them to the wall when PSW #102 was turning resident #001. Resident #001 said, "I was disappointed and it made me upset." Resident #001 demonstrated to inspector where they had sustained three injuries on an identified body part as a result of the incident and said, "I was emotionally upset."

In an interview PSW #102 indicated on the night of the incident they were informed by RPN #107 that resident #001 required two people to provide care for them. PSW #102 was directed by RPN #107 not to provide care to resident #001 on their own. PSW #102 said, " I accept that it was my fault, I went alone." PSW #102 acknowledged they pushed resident a little during care in order to provided personal hygiene. PSW #102 said, "there was no injury at the time."

In an interview, RPN #007 indicated that they were not there and said, "that night, I made it clear to PSW #102; I spoke to them adamantly not to provide care alone; call me or wait until I get back." RPN #107 also indicated that there was no injury noted at that time when they did resident #001's assessment.

In an interview, RN #103 indicated they received a report from RPN #107 that when RPN #107 went to see resident #001 they indicated that PSW #102 was rough with them during care. RN #103 indicated they did not go to assess resident #001 since RPN #107 had already assessed resident #001 and they were not aware that resident #001 sustained injury to an identified body part.

In an interview, unit manager #110 acknowledged from their understanding that PSW #102 did not follow the plan of care for resident #001 and what resident described to them could be viewed as physical abuse.

DOC #113 and ED #114 were made aware by inspector of the gaps identified during this inspection.

This finding is further evidence to support the order issued on July 16, 2019, during complaint inspection 2019_751649_0005 to be complied September 30, 2019.

Issued on this 30th day of October, 2019

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

Original report signed by the inspector.

Ontario

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2019_817652_0019
Log No. / No de registre :	013985-19, 016370-19, 017044-19, 017177-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 10, 2019
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 :	Simon Akinsulie

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:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

Order / Ordre :

The Licensee must be compliant with LTCHA, 2007, s.6. (4)

Specifically, the Licensee shall ensure when a resident who has been identified as high risk for nutrition related to two identified conditions, an interdisciplinary and collaborative team approach must be used to ensure:

1) Assessments conducted by members of the interdisciplinary team includes a review of the patient care notes.

2) The attending physician and the registered dietitian review the resident's discharge report and summary from the hospital to ensure all recommendations are reviewed and implemented if deem clinically appropriate for the resident. Once reviewed by the attending physician, the report must be signed and dated.

3) The home to implement their formal process for referrals to communicate any dietary changes to the registered dietitian especially if a resident has been identified at high nutritional risk.

4) Licensee to ensure that dietary aide #100 and any other dietary staff collaborate with the interdisciplinary team, when informed of any dietary issues related to a resident.

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

Grounds / Motifs :

1. 1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint through the Action-line on an identified date. This complaint indicated that during resident #002's stay with the home, they had sustained two episodes of an identified diagnosis that required a hospital admission and then returned to the home. This complaint also indicated on an identified date, resident #002 should have received an identified diet as per discharge records and those orders were not implemented by the home. During an identified time, resident #002 experienced the same symptoms and ultimately died from an identified diagnosis. The complainant reported that during an identified visit they noted that resident #002 was receiving an identified diet and when they questioned the dietary staff it was identified as per the hospital's discharge records that the texture change had not been implemented. In hindsight the complainant reported that after each identified meal time time during visits, they constantly asked why resident #002 was experiencing identified symptoms.

Record review of resident #002's healthcare records indicated the following dietary history:
- A referral form on an identified date, for resident #002 to be assessed by an external consultant related to identified symptoms. Resident #002 was on an identified diet type.The low risk indicators of an identified diagnosis checked on this form indicated identified symptoms.

- A physician's discharge summary from an identified hospital on an identified date, indicated resident #002's most responsible diagnosis. This report also indicated resident #002 was seen by an identified specialist who recommended an identified diet type and an identified diet texture was not allowed. This summary also indicated resident #002 was also at another identified hospital on an identified date for a similar identified diagnosis and was put on an identified medication at that time. It also went on to mention resident # 002 was on an identified food texture and had a history of an identified diagnosis.

- A report from an identified hospital on an identified date at an identified time, stated "resident #002 had a suspected un-witnessed medical event in their home on an identified date and were found to be experiencing identified symptoms.The discharged summary of this report instructed resident #002 to resume an identified diet type at the home and be reassessed by the physician if they developed identified symptoms, or any other symptoms that concerns them or the staff. Items for Follow-Up after Discharge addressed to the home indicated " Please change diet orders to an identified diet type. "

Record review of resident #002's patient care notes by RN #118 on an identified date and time indicated resident #002 returned from an identified hospital at an identified time with an identified discharged diagnosis and that resident was seen by an identified specialist who recommended an identified diet due to high risk of an identified diagnosis. This note also indicated the attending medical doctor was notified and resident #002 was seen by the attending physician who also held conversations with the family.

Record review of resident #002's patient care notes at an identified date and at an identified time by the attending physician, indicated readmission from hospital: called by nurse to report that resident arrived from hospital at an identified time returned to unit to reassess resident, family members at bedside, full discharge summary not available, from admission notes, resident was found to be experiencing identified symptoms at the time of admission, suspected identified diagnoses and required identified medical interventions. Prognosis initially thought to be very poor condition, improved slightly over the course of admission after discussions with family, decision was made to change focus to an identified level of care and repatriate resident to the home.

Record review of resident #002's patient care notes on an identified date and time, by former registered dietitian indicated resident #002 returned to the unit, with identified symptoms and suspected diagnoses. Resume an identified diet type, continue to monitor. On another identified date former RD indicated resident #002 was on this same diet type.

Record review of resident #002's identified assessment on an identified date, by the former RD indicated resident #002's identified diet type and texture, best consumed meal, location for dining, oral and clinical deficits and assistance

required during meals. There was no evidence in this assessment that resident #002's re-admissions diet order from an identified hospital to switch resident to an identified diet type and texture was implemented at the nursing home.

Record review of resident #002's identified medical reports for an identified period both indicated resident #002 was on an identified diet type and texture and, was started on an identified date.

Record review of resident #002's progress notes on an identified date by the attending physician indicated resident #002 showed identified symptoms and suspected an identified diagnosis and as per family, the medical doctor at an identified hospital had told the family that resident #002's diet was recommended to be downgraded to an identified texture after previous admission. This note also indicated the attending physician spoke to the home's registered dietitian who informed them that no documentation regarding downgrading resident #002's diet was sent with the resident after previous hospitalization. Resident was transferred to hospital due to worsened health status and passed away in hospital. No evidence of the cause of death was present on resident #002's chart.

Record review of resident #002's Medical Certificate of Death Form 16, on an identified date, provided to inspector by family member #116 confirmed resident #002's cause of death.

In an interview with family member #116 they indicated resident #002 was discharged from an identified hospital on an identified date, and there were two notes that said resident #002's diet needed to be changed to an identified diet type and texture because, that was the third time resident #002 had an identified diagnosis.
Family member #116 indicated the only reason they found out resident #002 was receiving the wrong diet, is when they visited the home, they found identified items on resident #002's plate; they were cut up large pieces and they made the kitchen staff aware that it was the wrong diet, and the kitchen staff said that resident #002 was on an identified diet. Family member #116 said, "no one had changed the notes in the computer when resident #002 returned on an identified date, from the hospital with recommendation to be put on an identified diet."

In an interview with dietary aide #100 they acknowledged that they remembered resident #002 was on an identified diet and their family member #116 approached them that resident #002 should have been on an identified modified diet and that's when they checked the black book (diet list) and it had an identified diet for resident #002. Dietary aide #100 indicated they were not aware that resident #002 should have been on an identified diet prior to the family bringing forth the concern, and they did not communicate with the nurse on the unit at the time that the family members had concerns regarding resident #002's diet type. They also went on to say they thought the registered dietitian was aware and did not communicate this to their manager or the dietitian until three days after the incident. Dietary Aide #100 indicated if such a situation should re-occur they would call the manager to handle the case.

In an interview with Registered Dietitian (RD) #114, they confirmed that resident #002's diet order had not been changed to an identified diet type and the discharged summary from an identified hospital did indicate to start resident on an identified diet type. Registered Dietitian #114 also indicated the dietitian's scope of practice allows them to write a dietary order and they do not have to wait for the physician to get an order. RD #114 and RN #118 also indicated the home does not utilize a formal process for implementing dietary referrals and referrals to the RDs can be in the form of voice messages, emails and verbally when on the units. There was no evidence to support a referral had been sent to former dietitian #119 on an identified date, when the hospital recommended resident #002's diet to be changed from one diet type to another. RD #119's documentation on an identified date, indicated staff to resume an identified diet for resident #002.

Former registered dietitian #119 responsible for resident #002's assessments and follow-up had retired from the home at the time of this inspection. Inspector attempted to contact this dietitian however their voice messaging system indicated that they were unable to receive calls.

Inspector was unable to interview attending physician due to the fact that they were on leave at the time of the inspection.

DOC #113 and ED #114 were made aware by the inspector of the non-

compliance identified during this inspection.

There was no evidence to support during this inspection that resident #002's diet had been changed to an identified diet type and texture based on the last recommendations from the hospital when resident #002 was readmitted to the home on an identified date.

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint through the Action-line on an identified date related to the prevention of abuse and neglect.

MLTC received a critical incident system (CIS) report on an identified date and time. This CIS indicated on an identified date, resident # 001 reported that PSW #102 pushed resident #001 during care while assisting to turn resident #001 in bed. Resident #001 claimed an identified body part hit the wall.

Record review of resident #001's progress notes on an identified date indicated resident #001 reported to RPN #107 that PSW #102 was rough with them during care.

Record review of resident #001's identified assessment on an identified date , indicated they had two identified injuries on an identified body measuring 1 cm x 1.5 cm (both same size).

In an interview resident #001's family member #115 confirmed that resident #001 reported to them that on an identified date and on an identified shift,PSW #102 was abusive to them and resident #001 was very upset and they sustained injury to an identified body part. Family member #115 also indicated they visited resident #001 the next day on an identified date, and, saw injury to resident #001's identified body part. Family member #115 indicated resident #001 was supposed to have two staff members provide care and PSW #102 did not follow resident #001's plan of care.

In an interview resident #001 indicated that they were pushed and rough handled by PSW #102 during care and two people were required to provide care

however PSW #102 provided care on their own when this incident occurred.

In an interview PSW #102 indicated that on the night of the incident they were informed by RPN #107 that resident #001 required two people to provide care for them. PSW #102 was directed by RPN #007 to not provide care to resident #001 on their own. PSW #102 said, " I accept that it was my fault, I went alone."

In an interview RPN #107 indicated that they were not there and said, "that night, I made it clear to PSW #102 and said, "I spoke to them adamantly not to provide care alone; call me or wait until I get back."

In an interview RN #103 indicated they received a report from RPN #107 that when RPN #107 went to see resident #001 they indicated that PSW #102 was rough with them during care and resident #001 required two people for care.

In an interview unit manager #110 acknowledged from their understanding upon the home's investigations that PSW #102 did not follow the plan of care for resident #001.

DOC #113 and ED #114 were made aware by the inspector of the non-compliance during this inspection.
The severity of this issue was determined to be a level 3 as there was actual risk to resident. The scope of the issue was a level 1 as it was isolated. The home had a level 3 history as they had previous written notification (similar area) of the LTCHA, O. Reg. 79/10, that included:
1)VPC issued November 28, 2018 (2018_530726_0007); 2) VPC issued November 13, 2018; (2018_524500_0013). (652)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

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 10th day of October, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Natalie Molin

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