Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: July 31, 2025

Inspection Number: 2025-1523-0006

Inspection Type:
Complaint
Critical Incident

Licensee: The Ottawa Jewish Home for the Aged

Long Term Care Home and City: Hillel Lodge, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 30, 2025 and July 2-4, 7-10, 15-18, 22- 25, 28 and 29, 2025.

The following intake(s) were inspected:

- Intake: #00144281 - Fall of a resident resulting in injury.
- Intake: #00147251 - Alleged physical abuse to a resident by another resident.
- Intake: #00147946 - Fall of a resident resulting in injury.
- Intake: #00148764 - Alleged abuse of a resident by a staff member.
- Intake: #00149021 - Fall of a resident resulting in injury.
- Intake: #00149307 - A missing resident.
- Intake: #00149843 - Complainant with concerns regarding a missing resident.
- Intake: #00151526 - Fall of a resident.
- Intake: #00152103 - Fall of a resident resulting in injury.

The following **Inspection Protocols** were used during this inspection:

Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer necessary. Specifically, the plan of care was not revised to remove the use of a specific mobility device when it was no longer used and to include the use of two positioning devices when the resident was no longer ambulating.

Staff provided the inspector with an updated copy of the resident's plan of care which had been reviewed to remove the use of the mobility device and to include the use of the positioning devices.

Date Remedy Implemented: July 25, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there is a written plan of care for a sets out clear directions to staff and others who provide direct care to the resident. Specifically, a resident's plan of care had specific instructions for providing assistance with an activity of daily living however, the instructions provided in another format was not the same.

Sources: Observation of inspector and interview with registered staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

1) The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan. Specifically, on a certain date there was no identification of the resident present at at a specific location in the home and the staff was not informed of the resident's behaviour or the intervention to manage the behaviour as directed in the resident's plan of care.

Source: resident's electronic health record, Home's investigation file, and Interviews with staff members.

2) The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan. Specifically, the resident did not have their specific clothing item on at the time of the fall as specified in the plan of care and confirmed by staff.

Sources: Resident's health records and Interview with staff.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee

knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that the alleged incident of abuse of a resident that was reported to the licensee was immediately investigated, as confirmed by the Chief Executive Officer (CEO).

Sources: home's investigation file and interview with the home's CEO.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to ensure that a final report of a Critical Incident Report (CIR) was submitted to the Director within 21 days as specified in the MLTC Reporting Requirements for LTC Homes.

Per Ministry of Long-Term Care Reporting Requirements for LTC Homes, dated October 2022 (updated June 2023); If the licensee cannot provide the material listed above within 10 days, the licensee must submit a preliminary report with the information available. The final report must then be submitted within 21 days of

becoming aware of the incident, or earlier if required by the Director.

Sources: review of the CIR and interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee has failed to ensure that the Critical Incident Report (CIR) submitted to the Director as per the legislation, set out the correct name of any staff members or other persons who were present at or discovered the incident. Specifically, a CIR was submitted to the Director on a specific date that did not have the name of the staff members who were present and responded at the time of the fall of a resident on a specific date.

Sources: Review of the CIR and Interviews with staff members.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (3)
Additional training — direct care staff
s. 261 (3) The licensee shall ensure that the training required under paragraph 2 of subsection 82 (7) of the Act includes training in techniques and approaches related to responsive behaviours.

The licensee has failed to ensure that all direct care staff received annual retraining in Behaviour Management as confirmed by staff.

Sources: staff's education report, interview with staff members.

COMPLIANCE ORDER CO #001 Plan of care

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Review the home's process for updating the residents' plan of care with the home's registered nursing staff to ensure they are aware of who is responsible for

the update, when and how to update the plan of care.

B) Conduct audits for all residents, who have fallen, to ensure that the residents' plan of care has been reviewed and revised at any time when, the resident's care needs change or the care set out in the plan is no longer effective. Take corrective actions if the plan of care has not been reviewed or revised. Audits are to be conducted by a member of the nursing management team until the order has been complied.

C) Keep written records of everything required under step A) and B). Written records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

1) The licensee has failed to ensure that a resident's plan of care was reviewed and revised when care set out in the plan had not been effective. Specifically, a resident's plan of care was not reviewed and revised after they had fallen on a specific date.

Sources: the resident's plan of care, and interview with staff.

2) The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective. Specifically, a resident's plan of care was not reviewed and revised when the resident had fallen on seven specific dates, as confirmed by staff.

Sources: resident's electronic health record and interview with staff.

This order must be complied with by August 12, 2025

COMPLIANCE ORDER CO #002 Required programs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Provide education on the home's Falls prevention and management program, specifically the home's post fall huddle and clinical monitoring record - V4 (SPN), to the home's registered nursing staff to ensure they are aware of what the assessments are and when they are required to be completed.

B) Conduct audits for all residents, who have fallen, to ensure that the Post fall huddle and the Clinical monitoring Record - V4 (SPN) have been completed. Take corrective actions if the Post fall huddle and the Clinical monitoring Record - V4 (SPN) have not been completed. Audits are to be conducted by a member of the nursing management team until the order has been complied.

C) Keep written records of everything required under step A), and B). Records must

be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied.
As per the home's falls program, section 15-01-02, Program elements and policies and procedures documents that: the program includes clinical assessments immediately post-fall and ongoing 72 hours monitoring these assessments include: Post Fall Huddle.
As per O. Reg. 246/22 s. 11. (1) (b), Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any program, the licensee is required to ensure that the program (b) is complied with.

1) The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied. with when a post fall huddle was not completed after a resident's fall on a specific date, as confirmed by staff.

Sources: residents health record and interviews with staff members.

2) The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied with when a post fall huddle was not completed after a resident's fall on a specific date in 2025.

Sources: the home's Falls Program titled Falls Program, resident's health record and interview with staff.

3) The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied with when a post fall huddle was not completed after a resident's fall on a specific date in 2025.

Sources: the home's Falls Program titled Falls Program, resident's health record and interview with staff.

4) The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied with when a post fall huddle was not completed after a resident had fallen fall on four specific dates in 2025, as confirmed by staff.

Sources: resident's health records and interview with staff.

5a) The licensee has failed to ensure that the home's program, titled Falls Program with last review date of July 2025, was complied with when a post fall huddle was not completed after resident had fallen on falls on six specific dates in 2025 as confirmed by the staff.

Sources: Home Falls Program, resident's health record and interviews with staff members.

5b) The licensee has also failed to ensure that the home's program titled Falls Program, including the appendix document titled Steps After Fall, that documented the procedure to complete the Clinical monitoring Record - V4 (SPN) for unwitnessed falls or head injury every hour for four hours then every shift for 72 hours, was complied with. Specifically, after the a resident had fallen on six specific dates in 2025 there were multiple instances when the clinical monitoring record was not completed as per the time frame specified.

Sources: Home Falls Program and appendix Steps After Fall, resident's health record, and interview with staff members.

This order must be complied with by September 12, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Inspection: 2022-1523-0001
Dated: 2023-01-05
Compliance Order High PriorityO. Reg. 246/22 s. 53 (1) 1.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #003 Falls prevention and management

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

A) Provide education on the home's Falls prevention and management program,

specifically the home's post-fall assessment, to the home's registered nursing staff to ensure they are aware of what the assessment is and when it is required to be completed.

B) Conduct audits for all the residents, who have fallen, to ensure that the Post fall assessment has been completed. Take corrective actions if the Post fall assessment has not been completed. Audits are to be conducted by a member of the nursing management team until the order has been complied.

C) Keep written records of everything required under step A), and B). Records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

1) The licensee has failed to ensure that when a resident had fallen, on a specific date in 2025, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls as confirmed by staff.

Sources: resident's health record and interview will staff.

2) The licensee has failed to ensure that when a resident had fallen, on a specific date in 2025 the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls as confirmed by staff.

Sources: resident's electronic health record, home's risk management system and interview with staff.

3) The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. Specifically, during two months in 2025 a resident had a number of falls and no post fall assessment was completed

Sources: resident's health record and interview with staff members.

4) The licensee has failed to ensure that a post-fall assessment was completed using a clinically appropriate assessment instrument that was specifically designed for falls for a resident after their fall as confirmed by staff.

Sources: resident's electronic health record, home's risk management system and interview with staff.

5) The licensee has failed to ensure that when a resident had fallen, on four specific dates in 2025, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls as confirmed by staff.

Sources: Resident's health records and interview with staff.

This order must be complied with by September 12, 2025

COMPLIANCE ORDER CO #004 Training

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.
Training

s. 82 (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:

A) Provide education and training on the home's Falls Prevention and Management Program to the remaining 35 (27.78%) direct care staff that has not been trained as of July 28, 2025.

B) Keep a written record of everything in section A). Records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that all staff who provide direct care to residents received additional training, specifically related to falls prevention and management, and that such training was conducted annually.

Pursuant to O. Reg. 246/22, s. 261 (1) 1, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents, specifically, falls prevention and management.

Pursuant to O. Reg. 246/22, s. 261 (2), The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act, annually.

Sources: Staff Education History Report and interviews with staff.

This order must be complied with by October 20, 2025.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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