Ontario

**Ministry of Long-Term Care**

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

**Ministère des Soins de longue durée**

**Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée**

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

**Public Copy/Copie du rapport public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 15, 2020 | 2020_814501_0005 | 012969-20 | Critical Incident System |

**Licensee/Titulaire de permis**

Bethany Lodge
23 Second Street MARKHAM ON L3R 2C2

**Long-Term Care Home/Foyer de soins de longue durée**

Bethany Lodge
23 Second Street MARKHAM ON L3R 2C2

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

SUSAN SEMEREDY (501)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): July 2, 3, 6, 7, 8, 2020. An off-site telephone interview was conducted July 10, 2020.**

**During this inspection the following critical incident intake was inspected: Log #012969-20**

**During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Life Enrichment Manager, physiotherapist, registered dietitian, physician, food service manager, registered practical nurses (RPNs), and personal support workers (PSWs).**

**During the course of inspection, the inspector conducted observations of staff and resident interactions and the provision of care, reviewed health records, home's investigation notes, notes from the hospital, and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection: Nutrition and Hydration**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

1. The licensee 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 home submitted a critical incident system (CIS) report regarding resident #001's substitute decision-maker (SDM) submitting a complaint regarding concerns around circumstances prior to the resident passing away.

A review of the hospital records indicated resident #001 was admitted with specified medical conditions. At the hospital the resident seemed to get better with interventions but then unexpectedly passed away.

A review of the home's progress notes indicated changes in health status occurred at least 10 days prior to hospitalization. Many of these changes were related to signs and symptoms related to a change in nutritional/hydration status. A review of a dietary report indicated a significant decline to resident #001 started occurring at least 10 days prior to hospitalization.

In separate interviews with PSW #102 and #103 they indicated resident #001 during their last week at the home needed more assistance. Both PSWs indicated they reported their concerns to the registered staff.

In an interview with RPN #104 they indicated they were aware of signs and symptoms of changes in nutritional/hydration status and noted resident #001 was having these but was waiting for the physician to assess the resident. RPN #104 stated they passed all the information to the physician but thinks someone else referred the resident to the

registered dietitian.

In an interview with RPN #110 they indicated they were aware of signs and symptoms of changes in nutritional/hydration status and stated the staff kept telling them resident #001 was refusing to eat and drink but did not make a referral to the registered dietitian because the resident was already receiving interventions. RPN #110 stated they did not inform the physician of resident #001’s signs and symptoms because the resident was not in distress.

In an interview with RPN #111 they indicated they were aware of signs and symptoms of changes in nutritional/hydration status and indicated they did not refer resident #001 to the registered dietitian or the physician because they knew the day shift was aware of the resident’s condition and had already talked to the physician.

In an interview with RPN #109 they indicated they were aware of signs and symptoms of changes in nutritional/nutritional status and verified they documented resident #001 had such symptoms. RPN #109 indicated it was the day shift that would inform the physician of such concerns.

During an interview with physician #107 they indicated they were notified that resident #001’s SDM wanted to speak with them but when consulted with the registered staff, did not think there was anything acute going on with the resident and decided to see them the next week on their regular rounds. The physician stated that when they saw the resident six days later they decided to order tests. The physician indicated they were not informed that the resident’s intake had significantly decreased for at least nine days and stated if they had known, they would have investigated sooner.The physician also stated they were not informed the signs and symptoms were escalating after the tests were ordered.

In an interview with acting Food Service Manager #100 they indicated they never received a referral from nursing regarding resident #001. During an interview with Registered Dietitian #101 they indicated they never received a referral from nursing regarding resident #001 and would have expected to be notified not only because of the resident’s documented decline in intake, but also due to their overall change in health status.

During an interview with Assistant Director of Care (ADOC) #108 they indicated that the expectation would be for nursing to monitor the resident’s nutrition/hydration status and if

changes occur such as poor food and fluid intake, a referral should be made to the registered dietitian. In this case, the ADOC was unaware if this had occurred. The ADOC also indicated that the physician should have been notified earlier when the resident was presenting with signs and symptoms of changes in nutritional/hydration status.

The licensee failed to ensure that nursing staff collaborated with the physician and registered dietitian regarding changes in resident #001's health status so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The license has failed to ensure that the nutrition care and hydration programs included the development and implementation of policies and procedures relating to nutrition care and hydration, in consultation with a dietitian who is a member of the staff of the home.

The home submitted a critical incident system (CIS) report regarding resident #001's substitute decision-maker (SDM) submitting a complaint regarding concerns around circumstances prior to the resident passing away at the hospital. According to the SDM, the resident passed away shortly after being admitted to the hospital.

The home provided three policies related to hydration and referrals to the registered dietitian (RD):
1. "Resident Nutrition Services – Hydration" Index I.D. D8008 revised May 2019
2. "Nutrition Care Monitors" #D006 revised August 2015
3. "Monitoring Resident Food and Fluid Intake #C015 revised January 2014

In reviewing the above policies, the following concerns were noted:

The first policy related to hydration is from a Food Service Manual. In relation to referrals being made to the RD, it states that nursing notifies the RD of any residents who are not consuming adequate fluid or who are displaying clinical signs of dehydration as per nursing protocol. It also states that nursing will monitor resident's fluid consumption through direct observation and intake reports and will inform physician, RD and other team members when a resident consumes less than half of all liquids for a period of 3 or more days. The policy does not state if all liquids refers to those served or a resident's fluid requirement.

The second policy related to nutrition care monitoring which also appears to be taken from the same Food Service Manual states nursing monitors resident's nutritional status and if changes occur completes the dietary referral and forwards to the RD immediately. A review of the form titled "Dietary Referral and Communication Form" indicates a request for RD assessment is for various reasons and includes poor flood intake (eating less than 50 per cent) and poor fluid intake [less than 1000 millitres (ml) per day]. Both these items do not indicate any time period for the poor intake.

The third policy related to monitoring resident food and fluid intake appears to be a home specific policy and states that if a resident's overall intake is less than half of the food served for three consecutive days, notify the RD suing the Dietary Communication and

referral sheet.

During an interview with RD #101, they indicated the above three policies are vague and, in some cases, contradict each other. The RD stated the first policy does not indicate what “half of all liquids” refers to but may refer to a resident’s calculated fluid requirement. The RD indicated the second policy and form indicates that fluid intake less than 1000 ml per day is to be considered poor fluid intake which is different than “half of all liquids”. This policy also does not specify how many days of poor intake are to be considered in terms of both food and fluid intake. The RD stated the third policy is more specific for the food intake but does not specify any amount or time period for poor fluid intake.

RD #101 who is a member of the staff acknowledged the home has not consulted them on the implementation of policies and procedures related to nutrition care and hydration. [s. 68. (2) (a)]

***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 nutrition care and hydration programs include the development and implementation of policies and procedures relating to nutrition care and hydration, in consultation with a dietitian who is a member of the staff of the home, to be implemented voluntarily.***

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**Issued on this 15th day of July, 2020**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère 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

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

**Name of Inspector (ID #) / Nom de l’inspecteur (No) :** SUSAN SEMEREDY (501)

**Inspection No. / No de l’inspection :** 2020_814501_0005

**Log No. / No de registre :** 012969-20

**Type of Inspection / Genre d’inspection:** Critical Incident System

**Report Date(s) / Date(s) du Rapport :** Jul 15, 2020

**Licensee / Titulaire de permis :** Bethany Lodge
23 Second Street, MARKHAM, ON, L3R-2C2

**LTC Home / Foyer de SLD :** Bethany Lodge
23 Second Street, MARKHAM, ON, L3R-2C2

**Name of Administrator / Nom de l’administratrice ou de l’administrateur :** Basil Tambakis

To Bethany Lodge, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / No d'ordre :** 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 s.6(4) of the LTCHA 2007.

Specifically, the licensee must:

1. Develop and implement strategies for all registered staff to follow when a resident's condition changes/declines including, but not limited to, collaborating with the resident's primary physician and registered dietitian.
2. Ensure that the above strategies are communicated to all registered staff by developing and providing an in-service that includes a means to confirm the information has been understood. Documentation of the strategies and training must be made available to the inspector when requested.
3. Ensure the registered dietitian completes a nutritional assessment when a resident's health condition changes/declines which includes hydration status and any risks related to hydration.

**Grounds / Motifs :**

1. The licensee 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 home submitted a critical incident system (CIS) report regarding resident

#001's substitute decision-maker (SDM) submitting a complaint regarding concerns around circumstances prior to the resident passing away.

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The licensee failed to ensure that nursing staff collaborated with the physician and registered dietitian regarding changes in resident #001’s health status so that their assessments were integrated, consistent with and complemented each other.

The severity of this issue was determined to be actual risk of harm to the resident. The scope of the issue related to one of three residents reviewed. The home had a history of previous noncompliance to a different subsection.

(501)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Nov 20, 2020

## 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 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 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 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 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 15th day of July, 2020**

**Signature of Inspector / Signature de l’inspecteur :**

**Name of Inspector / Nom de l’inspecteur :** Susan Semeredy

**Service Area Office / Bureau régional de services :** Central East Service Area Office