Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2015	2015_381592_0016	O-002180-15	Critical Incident System

Licensee/Titulaire de permis

THE OTTAWA JEWISH HOME FOR THE AGED
10 Nadolny Sachs Private Ottawa-Carleton ON K2A 4G7

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

HILLEL LODGE
10 NADOLNY SACHS PRIVATE OTTAWA ON K2A 4G7

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

MELANIE SARRAZIN (592)

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): June 16, 17, 18, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Coordinator of Quality Management Program, Registered Nurse, Personal Support Workers and an identified resident.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care must be based on, at a

minimum interdisciplinary assessment of the following with respect to Resident #001's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

On a specified date , Resident #002 was found by PSW #102 in his/her bed with the call bell cord loosely wrapped around a specific body part and a pillow across his/her chest. PSW #102 found roommate, Resident #001 hiding between Resident #002's privacy curtains.

On June 16, 2015, inspector #592 spoke with the DOC who indicated that immediately following the incident, one on one monitoring of Resident #001 was implemented. In addition, she told inspector #592 that the Outreach Nurse was contacted and the home had received the instructions by the Royal Ottawa Hospital (ROH) to transfer Resident #001 to a private room, which was done 6 days after the incident. She further added that one on one monitoring was provided to Resident #001 after he/she was transferred to the private room. One on one monitoring was discontinued as Resident #001 behaviours were stable. Cohen's Mansfield, Behaviour Audits and blood work were also part of the home's follow-up after the incident. DOC also told inspector that Resident #001, was placed on a suicidal watch due to sad mood and negative statements expressed after the incident, as recommended by ROH. She told inspector #592 that both residents were still residing on the same unit and that staff were doing increased visual checks of the Resident. She further told inspector #592 that there were two instances were staff observed Resident #001 pushing Resident #002 's wheelchair but no other interactions were brought to her attention since the incident.

Inspector #592 reviewed Resident #001 health records, which indicated that Resident #001 is diagnosed with a specific Cognitive Disorder. In addition, Resident #001 is also identified by being resistive with personal hygiene, getting upset when other residents wander into his/her room and at risk of elopement.

Current Plan of care reviewed and does not indicate any interventions following the incident to reflect the new potential triggered behaviours and actions to take in response to the needs of the resident.

On June 17, 2015, Inspector #592 spoke with PSW #102 and #103 who both confirmed that since Resident #001 has been moved to a private room, there were no specific interventions or instructions given to them for potential behavioral triggers or specific visual checks for Resident #001.

On June 17, 2015, Inspector #592 spoke with RN #101 who indicated that since the incident, she witnessed resident #001 going up and down the hall and give Resident #002 hugs and kisses and telling the resident how he/she was missing him/her. She further added that there was no additional monitoring of resident in place.

Progress notes reviewed and does indicate that on June 12, 2015, the social worker reported to Registered staff member by unit PSW that resident #001 was seen pushing resident #002 from a room down the hallway to a specified room on two separate occasions on June 11th.

On June 17, 2015, inspector #592 spoke with the DOC who indicated that she was not aware that Resident #001 was still interacting with Resident #002 other than the two instances where Resident #001 was observed pushing the wheelchair of Resident #002. She confirmed with inspector #592 that the Plan of care for Resident #001, had not been updated after the incident to identify responsive behaviours, potential behavioural triggers and interventions to respond to the needs of the resident. [s. 26. (3) 5.]

Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.