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

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

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

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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
Oct 31, 2016	2016_200148_0037	020484-16, 021240-16, 026578-16, 027514-16	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

AMANDA NIXON (148)

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): October 18, 19 and 20, 2016.

This inspection included four critical incidents, each related to alleged resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator (ED/CEO), Director of Care (DOC), Director of Social Work and Program Support Services (DSWPS), Registered nursing staff, Personal Support Workers and residents.

The Inspector also reviewed resident health care records, documents related to the licensee's investigations into the incidents and observed residents on their respective unit.

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)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the right of every resident to be properly sheltered,

fed, clothed, groomed and cared for in a manner consistent with his or her needs is respected and promoted.

The plan of care for resident #005, describes the resident to be at risk of choking and/or aspiration. Further to this, a nutritional assessment, indicates recent aspiration pneumonia. The plan focus for eating, indicates the resident requires extensive feeding assistance and texture modified food. After an incident, as described below, the plan was updated to include that the resident is to be brought to the dining room to eat. Resident #005 has impaired cognition related to current medical diagnosis and the resident is not able to make health care decisions.

On an identified date, PSW #101, heard resident #005 screaming in the resident's bedroom. PSW #101 entered the bedroom to see a visitor feeding the resident in a forceful manner. PSW #101 noted the resident to be crying, the PSW intervened to cease the activity.

Inspector #148 reviewed the health care record including the progress notes. Four notes were discovered that indicate staff members reporting concern about the feeding techniques used by resident #005's identified visitor, exampled by the following:
- On an identified date, the DSWPS indicates that a meeting was held with resident #005's visitor, CEO, DOC and charge nurse to address the issue of reports of force feeding resident #005. The identified visitor was informed that forcing resident #005's mouth open was unacceptable and constitutes abuse and will not be tolerated in the home.
- On an identified date, RPN #106 indicates that staff reported concerns that an identified visitor of resident #005 was forcing the resident's mouth to open while yelling at the resident. The RPN informed the visitor that the actions were not acceptable.
- On an identified date, the DSWPS indicates that a meeting was held with resident #005's visitor about the aggressive approach to feeding resident #005, as staff and other person report force feeding against resident #005's wishes. DSWPS reiterated that the identified visitor has to be careful in how he/she provides nourishment to resident #005 so that the actions do not become reportable to the authorities
- On an identified date, RN #105 indicates that the resident was lethargic and awake in the dining room, not able to eat any food. The RPN then describes that the resident's visitor was pushing food into the residents mouth. The RN intervened and educated the visitor that pushing food into the resident's mouth may increase the resident's choking risks. The visitor then took the resident and meal to the resident's bedroom.
- On an identified date, the DSWPS, indicated that a PSW #101 reported to the CEO,

DOC and DSWPS about the incident that occurred seven days prior, as described above. The progress note indicates that the resident's POA for care, physician and the Ottawa Police were informed.

Inspector #148 spoke with registered nursing staff and three PSWs who regularly work on the unit where resident #005 resides, including day and evening shifts. When asked to describe the feeding technique used by the identified visitor when feeding resident #005, the staff described the visitor forcing the resident's mouth to open and pushing food into the resident's mouth. When asked how often this type of feeding would be provided by the identified visitor, PSW #103 and #104, said "all the time". PSW #102, described occasions whereby resident #005 would be brought into the dining room for meals, the identified visitor would arrive and begin to feed. She noted that the resident would begin to refuse to eat, the visitor would appear frustrated and would take the resident and the meal to the resident's bedroom. The visitor would then exit the bedroom some time later indicating the resident had consumed the meal. The staff interviewed were concerned when the resident was taken into the bedroom as they were not sure what feeding was being provided. The staff reported that they took no action when the identified visitor took the resident to the bedroom to feed the resident.

Through interviews with the DOC, DSWPS and ED, it was determined that senior managers of the home were aware of resident #005's identified visitor using inappropriate feeding techniques to feed the resident, as described above. Each, were aware that this behaviour was continuing despite conversations with the identified visitor to cease such feeding techniques. It was also their knowledge that the visitor would feed the resident in the resident's room with the door closed, where the feeding techniques used could not be observed and/or monitored. In discussion of the feeding techniques, the managers agreed that if a staff member or volunteer had been observed to feed a resident in this manner that immediate action would have been taken to cease the behaviour. On a specified date, after the report from PSW #101, the management team contacted the MOHLTC, police force and restricted the identified visitor's visits. As described by the ED in a letter to the identified visitor, the incident described by PSW #101, was abuse toward resident #005.

The licensee did not fully respect and promote resident #005's right to be properly fed in a manner consistent with his/her needs, whereby the resident, as described, was forced fed on several occasions. The licensee spoke with the identified visitor, at minimum, on three occasions to cease the behaviour, without success. No further action was taken until the incident reported by PSW #101. [s. 3. (1) 4.]

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 resident #005 is properly fed and cared for in a manner consistent with his/her needs, to be implemented voluntarily.

Issued on this 1st day of November, 2016

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

Original report signed by the inspector.