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
Nov 28, 2016	2016_380593_0031	031905-16	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

GILLIAN CHAMBERLIN (593)

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): November 4, 7, 2016.

One intake was inspected during the inspection. Critical Incident log #031905-16, related to allegations of abuse and neglect toward a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Social Worker, Registered Nursing Staff, Personal Support Workers (PSW), Physiotherapist (PT), residents and family members.

The inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, licensee investigation records and home policies.

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

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Under O.Reg. 79/10, physical abuse is defined as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A written complaint was received by the home related to an injury that resident #001 sustained to a specific area of their body. The details of the complaint stated that the complainant believed that the resident was injured while being transferred and requested that the home investigate the incident to find out what happened.

The home contacted the LTC Home emergency pager on a specific date in relation to this incident. The details included in the report were that the incident occurred this same day, as at this time the complainant was alleging that the home were hiding abuse.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of alleged staff to resident physical abuse. It was reported that resident #001 was found with unexplained swelling and bruising to a specific area of their body. Upon further assessment, the resident was diagnosed with a fracture. It was reported in the CI that the family were upset and accusing the home of

hiding and covering up the truth and that they were negligent.

During an interview with Inspector #593, November 4, 2016, RPN #100 reported that she was informed about the injury approximately 0800 hours, the day it was alleged to have occurred, by two PSW staff who were providing care to resident #001. RPN #100 confirmed that she called the DOC and left a voice message regarding the injury later that morning.

Nursing progress notes indicated that the injury was first discovered during morning care, was assessed by the physician who recommended further investigation due to a possible fracture and that a message was left during the day shift for the DOC related to the injury. A further progress note indicated that the results of the x-ray were received and a fracture was confirmed.

The CI was submitted on a specific date, however the incident actually occurred more than six days earlier than when the incident was first reported to the Director and three days after the DOC was aware of the incident and had received confirmation that resident #001 had sustained a fracture, and five days after the licensee had received a written complaint regarding the incident.

During an interview with Inspector #593, November 7, 2016, the DOC reported that they did not know about the injury until three days after it had occurred as they were not in the home the day that it was discovered and did not receive the message from RPN #100 until three days after the injury was discovered. The DOC further reported that they did not believe that anybody would abuse this resident which is why they did not report the incident to the Director until the family alleged physical abuse of resident #001. [s. 24. (1)]

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 ensuring that all suspicions of a abuse by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident are immediately reported to the Director., to be implemented voluntarily.

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Issued on this 28th day of November, 2016

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

Original report signed by the inspector.