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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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_0030	031598-16, 031755-16	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): November 4, 7, 2016.

Two intakes were inspected during the inspection. Complaint log's #031598-16 and #031755-16, both related to care concerns and 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:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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 LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident of the long-term care home, was immediately forwarded to the Director.

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.

A review of the nursing progress notes by Inspector #593, indicated that the injury referenced in the written complaint 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 progress note indicated that the results of the x-ray were received and a fracture was confirmed.

During an interview with Inspector #593, November 7, 2016, the DOC reported that they did not immediately forward the written complaint to the Director as they did not believe it to be a complaint. The DOC further added that they believed that the complainant was requesting an investigation into the incident and at the time of the written complaint, it was not yet confirmed that a fracture had been sustained by the resident, however when a fracture was confirmed, the written complaint was still not forwarded to the Director. [s. 22. (1)]

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.