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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2017	2017_593573_0015	009579-17	Resident Quality Inspection

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

ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 23, 26, 27, 28, 29, 30, 2017 and July 04, 05 and 06, 2017.

The following Complaint and Critical Incident inspections were conducted concurrently during this Resident Quality Inspection:
Complaint Log #013591-17 related to resident care and services.
Critical Incident Logs #024590-16, and 026765-16 related to fall incident. Logs #029204-16, 004194-17 and 009402-17 related to an alleged resident neglect and 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), Director of Environmental Services, Food Service Manager, RAI Coordinator, Administrative Secretary, Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide, Activity staff, Dietary Aides, President of Residents' Council, family members and residents.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed medication administration passes, recreation activities, exercise therapy classes, meal and snack services, reviewed residents health care records, the Licensee's relevant policies and procedures, minutes for the Residents' Council. In addition Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **5 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not supervised by staff.

During the initial tour of the home on June 23, 2017, it was observed by Inspector #178 that the door to the Family Suite on first floor was unlocked. The suite contained a sofa, chairs, and included an ensuite washroom with a shower. No call bell was present in either the Family Suite or the attached washroom. A can of aerosol odour spray was observed on the washroom counter, and a can of stainless steel cleaner and polish spray was observed in the cupboard under the sink. The room was not attended by any staff.

During the initial tour on June 23, 2017, Inspector #178 also observed the Exam Room on third floor to be unlocked. The room contained a dentist's chair which was plugged into the outlet, a desk, and a vanity with a sink. A can of aerosol odour spray was observed in the cabinet under the sink. The room was not attended by any staff, and the door did not appear to be equipped with a locking mechanism.

Inspector #178 again observed the first floor Family Suite and the third floor Exam Room to be unlocked and unattended on June 28, 2017.

During an interview with Inspector #178 on June 28, 2017, the home's Director of Environmental Services indicated that the Family Suite and the Exam Room are not residential areas. He indicated that the Family Suite is normally kept locked unless it is in use by families or it's being cleaned. He also indicated that the Exam Room is used by the dentist, and is sometimes used by nursing, and he has never seen the Exam Room locked. The Director of Environmental Services indicated that he will ensure that both rooms are locked.

On June 30, 2017, Inspector #178 again observed both the first floor Family Suite and the third floor Exam Room to be unlocked.

On the morning of July 04, 2017, Inspector #178 observed the door to the Family Suite on first floor to be locked, and the door to the Exam Room on third floor to be unlocked. No staff or residents were present in or around the exam room.

During an interview with Inspector #178 on July 04, 2017, the Director of Environmental Services indicated that the Exam Room on the third floor is not currently equipped with a lock, but the home has contacted a locksmith to have a lock installed.

2. During the initial tour of the home on June 23, 2017, Inspector #178 observed that the door to the linen room on second floor east on the secure unit was closed but not locked. No staff was present in the room or in the hallway near the room. No residents were present in or around the room.

On July 04, 2017, at 1040 hours, Inspector #573 observed on the second floor east on the secured unit one linen room was kept unlocked. Inspector #573 observed that there was no call bell in the linen room. Further Inspector observed resident #049 was wandering in the hallway near the linen room. At the time of the observation there were no staff present in the area. Inspector spoke with RPN #110, who indicated that linen room was expected to be closed and kept locked at all times [s. 9. (1) 2.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there is no Family Council, the licensee convenes semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

During an interview between Inspector #178 and the home's Director of Social Work and Program Support Services (DSWPS) on Jun 23, 2017, the DSWPS indicated that she has acted in the past as a facilitator for the Family Council, but the home has been without a Family Council since May 17, 2016. The DSWPS indicated that she advertises for volunteers for the Family Council in the home's monthly newsletter, and spoke about the Family Council at a recent resident and family information meeting held April 01, 2017, but the licensee has not convened semi annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council. [s. 59. (7) (b)]

WN #3: 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 licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident body mass index and height upon admission and annually thereafter.

During the course of the inspection the Inspector(s) noted that residents' heights were recorded near a resident's admission to the home but were not completed on an annual basis.

On June 28, 2017, Inspector #573 spoke with the home's RAI coordinator, who indicated that residents height are taken upon admission and on annual basis. Further she indicated that resident heights are recorded in the point click care under vitals section or in the electronic medication administration record (eMAR).

On June 29, 2017, Inspector #573 reviewed resident's annual height in the presence of home's RAI coordinator. A review of the 20 sample residents demonstrated that resident #019, #026, #27, #29, #031, #032, #033 and #037 did not have a height measure in 2016, further with resident #014, #016 and #039's last height measured was in 2014. The RAI coordinator indicated to the inspector that for the identified 11 residents, there was a doctor's orders in the eMAR for the annual height. Further she indicated to the inspector that for the above identified 11 residents, the height was measured upon admission but was not conducted annually. [s. 68. (2) (e) (ii)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal.

Inspector #573 observed the lunch meal service in the two west unit's dining room on

June 23 and June 29, 2017.

According to the daily and weekly posted menu, on Friday, June 23, 2017, the planned lunch menu was hearty bean soup, baked penne casserole, wax beans, pear Melba and the alternate choice was egg salad plate, bread and yogurt. It was noted by Inspector #573 that the bread was not offered to the residents along with egg salad plate.

Inspector #573 observed residents were having cold egg salad plate without bread. Further Inspector did not observe any bread that was available or kept near the servery. For the dessert, PSW #114 offered residents a choice of apple sauce and yogurt. Inspector #573 spoke with PSW #114, who was serving the dessert, indicated to the inspector that residents were offered with apple sauce and yogurt. Inspector observed cups of pear Melba in the bottom tray of the dessert cart that was not offered to the residents.

On June 23, 2017, Inspector #573 spoke with Dietary Aide #112, who indicated that posted entrée alternate choice was cold egg salad plate. She did not indicate to the inspector that bread was included in the menu or to be served along with the egg salad plate. Further she indicated that posted lunch dessert menu was pear Melba or yogurt.

On June 29, 2017, Inspector #573 observed the lunch meal service in the two west unit's dining room. The planned and posted dessert menu included compote and the alternate choice of dessert was star cookies. For the dessert, PSW #115 offered residents with a choice of apple sauce and star cookies. Inspector #573 spoke with PSW #115, who indicated that for the dessert, residents were offered with apple sauce and star cookies. Inspector observed cups of compote in the bottom tray of the dessert cart that was not offered to the residents.

On June 29, 2017, Inspector #573 reviewed the therapeutic diet sheet and production sheet for June 23 and 29, 2017, in the presence of the Director of Food and Nutrition Services. She indicated to the inspector that residents are to be offered with the bread and the dessert as per the planned menu. Further she indicated that apple sauce is also available as the third choice for dessert if the residents does not like the planned dessert menu. [s. 71. (4)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Resident #009's room was observed by Inspector #573 on June 29, 30, 2017 and July 04, 2017, at various times of day to have a lingering odour of urine.

On June 30, 2017, Inspector #573 spoke with two PSW staff members regarding the odours in the resident #009's room. It was reported that the odours are known to exist and that it is primarily related to the behaviours of resident #009, where the resident will eliminate in the waste basket or on the floor.

On July 04, 2017, at 1050 hours, Inspector #573 observed resident #009's room in the presence of the regular day shift Housekeeping Aide #125, who agreed with the inspector regarding the lingering urine odour in the resident room. Housekeeping aide #125 reported to the inspector that she is aware of the lingering odour of urine in resident's room. She explained to the inspector that resident's room was scheduled to be cleaned twice a day and she uses Dettol and room refresher for odour control. Further staff #125 indicated that after cleaning resident #009's room, the odour returns and it is difficult to eliminate the lingering odour of urine.

On July 04, 2017, Inspector #573 spoke with the Director of Environmental Services for the home's procedure and policy on how to address lingering offensive odours in the home. He indicated to Inspector #573 that housekeeping staff were to use Dettol and Oxy D.S.T hydrogen peroxide based cleaner, where odours are a problem. Further he indicated to the inspector that there was no standard operating procedure or policy for staff in the home to address incidents of lingering offensive odours.

As such the licensee did not ensure that the home developed and implemented procedures for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Issued on this 12th day of July, 2017

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

Original report signed by the inspector.