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 # / No de registre	Type of Inspection / Genre d'inspection
Apr 25, 2018	2018_627138_0003	026042-17, 004717-18, 004815-18, 005314-18	Complaint

Licensee/Titulaire de permis

The Ottawa Jewish Home for the Aged
10 Nadolny Sachs Private OTTAWA 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

PAULA MACDONALD (138)

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): March 23, 26 - 29, and April 3 - 5, 2018.

This Complaint inspection was conducted concurrently with Complaint inspection #2018_627138_0004.

The following intakes were inspected:
026042-17 related to a resident care concern,
004815-18 related to alleged abuse of a resident and,
005314-18 related to a resident care concern.

Critical Incident System log #004717-18 related to alleged abuse of a resident was also inspected as part of this inspection. This intake is related to the same issue identified in log #004815-18 listed above.

During the course of the inspection, the inspector(s) spoke with residents, the Chief Executive Officer, the Director of Care, the Chief Financial Officer, the Occupational Therapist, receptionists, personal supports workers (PSWs), and registered practical nurses (RPNs).

The inspector also reviewed health care records, observed staff to resident interactions, reviewed the home's internal investigation documents, reviewed a complaint received by the home as well as the home's written response letter, and reviewed Human Rights Tribunal of Ontario documentation.

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

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001 has resided in the home for several months and has been assessed to be able to make their own decisions about care. Resident #001 made a complaint that they were repeatedly denied their request for assistance to get out of bed during the night by a specific night staff member for the past two months. Resident #001 stated that they wish to get out of bed at night to sit in a chair but require two staff for assistance as they are not able to get out a bed independently.

Discussion was held with the Director of Care regarding resident #001's complaint as described above. The Director of Care stated that the home was aware that resident #001 had some concerns with a specific night staff member and identified this staff member as PSW #100. The Director of Care stated that, at the present time, it was believed that resident #001's concerns had been rectified and further added that the home was unaware of the complaint identified above.

Resident #001's unit was visited during the end of a night shift and discussion was held with PSW #100. PSW #100 stated that resident #001 had been ringing the call bell all night for a total of twelve times asking to get out of bed. PSW #100 further stated that the resident was not provided assistance to get out of bed and gave the rational that there was only one staff on the resident's unit while the resident required two staff for transfers out of bed. After the discussion with PSW #100, another staff was identified on the unit, RPN #101, who reported working between this unit and another unit but was available to assist the PSWs as requested.

Discussion was held with Resident #001 once the resident was up for the day. Resident #001 confirmed to the inspector that they made multiple requests during the night for assistance to get out of bed but no assistance was provided. Resident #001 further stated that they felt frustrated that their wishes were not being respected.

Resident #001's plan of care, as defined by the home, was reviewed and it was noted that there was no indication that the resident's sleep pattern included expressed wishes for assistance out of bed during the night.

As such, Resident #001 has not had the opportunity to participate fully in the

development and implementation of the resident’s plan of care with respect to sleep patterns.

Log 005314-18 [s. 6. (5)]

Issued on this 26th day of April, 2018

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

Original report signed by the inspector.