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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2019	2019_627138_0001	016990-18, 024237-18, 032153-18	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 7, 8, 9, 10, 15, 16, 17, 18, 21, 22, and 24, 2019.

The following intakes were completed in this Critical Incident System Inspection:
Log #016990-18 related to alleged resident abuse,
Log #024237-18 related to alleged resident abuse and,
Log #032153-18 related to minimizing of restraining.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care, the Director of Social Work, Program & Support Services, the Chief Financial Officer (CFO), the Assistant Director of Nursing, the Nursing Admin Assistant, the Occupational Therapist (OT), an occupational therapy/physiotherapy assistant (OT/PT assistant), registered practical nurses (RPNs), personal support workers (PSWs), a behavioural support Ontario worker (BSO), health care aides (HCAs), and residents.

The Inspector reviewed resident health care records, observed residents, reviewed internal investigation documents, reviewed the licensee's policy relating to minimizing of restraints, and toured areas of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Légende 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. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that devices provided for in the regulation are not used on a resident to restrain the resident. In accordance with O. Reg 79/10 s. 112 (7), the licensee shall ensure that sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose are prohibited devices that limit movement of a resident.

Specifically, the licensee did not ensure that a device used to limited the body movement of resident #001 was prohibited.

1) A critical incident report was submitted to the Director at the end of 2018 that outlined an incident in which resident #001 was found restrained with a prohibited device.

The Inspector spoke with RN #112 and Assistant Director of Nursing #104 regarding the incident and it was determined that resident #001 was found while rounds were being conducted by PSW #118. Resident #001 was found with a prohibited device applied. Resident #001 was not able to move specific parts of their body. Resident #001 was reported to RN #112 who, in turn, reported the incident to the Assistant Director of Nursing #104. Both RN #112 and the Assistant Director of Nursing #104 viewed the resident being restrained. The resident was released from the prohibited device and assessed for any injury by RN #112.

The Inspector spoke to the Director of Social Work, Program & Support Services #103, who stated that the home had commenced an internal investigation into this specific incident and the home determined through their investigation that PSW #106 had applied the prohibited device. The Director of Social Work, Program & Support Services #103 also provided the Inspector with a copy of the home's restraint policy titled Restraint Management Protocols with a revision date of September 2, 2015. The Inspector noted that the policy outlined that the device used was not allowable as a restraint in the home.

The Inspector spoke with PSW #106 who stated that they had applied the (prohibited) device to resident #001. PSW #106 further stated resident #001 had a history of a specific injury and that applying the device to the resident was an intervention in place at the suggestion of family to prevent further injuries. PSW #106 also stated that this was a known intervention performed by staff for an approximate period of time. PSW #106 admitted to applying the device to resident #001's on multiple occasions.

The Inspector spoke with other staff about the care of resident #001. PSW #108 also stated that it was generally known amongst staff that resident #001 would have a (prohibited) device applied as an intervention to prevent injury. PSW #108 stated that they had seen the device applied to resident #001 and that PSW #108 had, themselves, applied the device to resident #001 to prevent the resident from moving specific parts of their body. PSW #108 stated the intervention occurred for an approximate period of time until the resident received a new device.

In summary, the licensee failed to ensure that a device applied to resident #001 that limited the movement of specific body parts was prohibited.

2) The Inspector reviewed the health care record for resident #001 in response to the above incident.

It was noted in the progress notes that the resident had sustained a specific injury. The progress notes indicated monitoring for the resident was initiated as a result of the injury. The Director of Care #102 stated that monitoring was provided to the resident for a specific time each day for three months and then periodically as needed thereafter.

Despite the monitoring, the progress notes for resident #001 indicated the initiation of a (prohibited) device, different than that used above, to prevent further injury. The plan of care, as defined by the home, at the time, was reviewed and it was noted that the resident was to have this device applied at specific times to prevent injury.

The Inspector spoke with the Assistant Director of Nursing #104 regarding the (prohibited) device provided to resident #001. The Assistant Director of Nursing #104 stated that they were aware of the use of the device and that the device had been fabricated for the resident. The Assistant Director of Nursing #104 further described the application of the device which limited the movement of the resident, preventing the resident from injury. The Assistant Director of Nursing #104 stated that the device was considered a restraint. The Assistant Director of Care #104 was able to confirm in the electronic charting system that the device was in use for resident #001 for approximately four months.

The Inspector spoke with RPN #111 about the (prohibited) device used for resident #001. RPN #111 describe the device as a restraint for resident #001 and described its application. RPN #111 stated that the device was used for the resident to prevent further

injuries but, over time, use of the device caused resident #001 to have specific injuries as a result of the application of the device. RPN #111 stated that it was at this time that physiotherapy/occupational therapy was consulted for additional alternatives to the device and, as a result, a new and specific device was obtained.

The Inspector reviewed the progress notes for resident #001 and noted three entries that outlined injuries to the resident in which the (prohibited) device was listed as a contributing factor.

The Inspector spoke with Occupational Therapist #116 who reported that staff had asked them to look at resident #001 as a result of injuries related to the (prohibited) device. Occupational Therapist #116 stated that they did visit resident #001 and they did view the application of the device to the resident. Occupational Therapist #116 described the device, the application of the device, and how it restricted the movement for resident #001 as a way of preventing injury. Occupational Therapist #116 stated that they viewed one of resident #001's injuries and determined that it was related to the device. Occupation Therapist #116 recommended the discontinuation of the device and obtained a new and specific device for resident #001 which would protect the resident from injury but still allow the resident to move. Occupational Therapist #116 stated that the new and specific device ordered arrived quickly and agreed that it was applied to the resident on a specific date with success.

In summary, the licensee failed to ensure that the device, fabricated for resident #001, was prohibited in limiting the movement of resident #001's body for four months, resulting in injury to the resident.

Log #032153-18 [s. 35. (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions for staff and others who provide direct care for the resident.

A critical incident report was submitted to the Director which outlined an incident that occurred in which resident #001 had been found with a prohibited device applied. PSW #106, who applied the device, stated that this was done as an intervention to prevent the resident from injury.

The Inspector spoke with Occupation Therapist #116 who stated that a new specialized device had been obtained for resident #001 to prevent injury and that this new specialized device was applied on a specific date.

The Inspector reviewed the health care record for the resident #001 and it was noted in the progress notes that the new specialized device was applied routinely to resident #001 since the date as told by Occupational Therapist #116.

The Inspector reviewed the plan of care, as defined by the home, and noted that there was no direction for approximately three weeks that a new specialized device was being used for resident #001 as an intervention to prevent injury.

As such, the licensee failed to ensure the written plan of care for resident #001 included the use of the new specialized device to prevent injury.

Log #032153-18 [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 19th day of February, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2019_627138_0001
Log No. / No de registre :	016990-18, 024237-18, 032153-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 4, 2019
Licensee / Titulaire de permis :	The Ottawa Jewish Home for the Aged 10 Nadolny Sachs Private, OTTAWA, ON, K2A-4G7
LTC Home / Foyer de SLD :	Hillel Lodge 10 Nadolny Sachs Private, OTTAWA, ON, K2A-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ted Cohen

To The Ottawa Jewish Home for the Aged, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 35. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 35.

Specifically the licensee shall:

Ensure that no device provided for in the regulations is used on resident #001 and any other resident to restrain the resident.

Ensure that an evaluation is completed within 45 days of this order being served, as per section O.Reg 79/10 s.113 (b), (c), (d) and (e), to determine the effectiveness of the licensee's policy under section 29 of the Act. The evaluation is to be kept and available for the Inspector to review on follow up.

Ensure, as per section O.Reg 79/10 s. 216 (2) that the training and orientation program related to the home's policy to minimize the restraining of a resident as outlined in LTCHA s. 76 (2) 6. is evaluated and updated within 60 days this order is served.

Ensure, as per O.Reg 79/10 s. 216 (3), that a written record of the evaluation of the training and orientation program is kept and is available for the inspector to review on follow up.

Grounds / Motifs :

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79/10 s. 112 (7), the licensee shall ensure that sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose are prohibited devices that limit movement of a resident.

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In summary, the licensee failed to ensure that the device, fabricated for resident #001, was prohibited in limiting the movement of resident #001's body for four months, resulting in injury to the resident.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2, indicating a pattern, as two of the three devices used with the resident were prohibited devices. The licensee had a level 2 compliance history with several unrelated non compliances in the past 36 months.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Log 032153-18 (138)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PAULA MACDONALD

Service Area Office /
Bureau régional de services : Ottawa Service Area Office