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
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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 8, 2019	2019_627138_0007	005201-18, 006439-18, 009560-18, 015720-18, 028499-18, 030086-18, 031553-18, 031570-18, 032415-18, 003867-19	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), EMILY BROOKS (732), SUSAN LUI (178)

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): April 15, 16, 17, 18, 23, 24, 25, 26, 29, 30 and May 1, 2019.

The following Follow Up intakes were inspected as part of this inspection:
log #003867-19 relating to minimizing of restraints and,
log #031570-18 relating to the home's skin and wound program.

The following Critical Incident System intakes were inspected as part of this inspection:
log #005201, log #028499-18, and log #032415-18 all relating to a fall of a resident,
log #030086-18 and log #031553-18 both relating to alleged abuse or neglect of a resident, and
log #015720-18 relating to missing/unaccounted controlled substance.

The following intakes were completed as part of this inspection:
log #009560-18 and log #006439-18 both relating to a fall of a resident.

During the course of the inspection, the inspector(s) spoke with registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), the Chief Executive Officer, the Chief Financial Officer, the Director of Care, and the Assistant Director of Nursing.

The inspectors observed residents, observed resident care areas, reviewed resident health care records, reviewed policies, reviewed internal investigation notes, observed medication storage, reviewed training records, and reviewed program assessment documents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 35.	CO #001	2019_627138_0001	138
O.Reg 79/10 s. 50. (2)	CO #001	2018_621547_0032	732

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A Critical Incident Report submitted by the licensee indicated that resident #003 was admitted with an indwelling urinary catheter. When the resident began to experience decreased urinary output, it was discovered that their urinary catheter had not been changed for five months.

Resident #003's plan of care was reviewed. Resident #003's plan of care in place indicated that the resident's urinary catheter should be changed every month.

On April 17, 2019, Inspector #178 interviewed the Assistant Director of Nursing #117, who indicated that several months ago, resident #003's urinary output began to decrease. While looking into the cause, it became known that resident #003's urinary catheter had not been changed in five months, in spite of the fact that the resident's plan of care indicated the catheter should be changed monthly. Assistant Director of Nursing #117 noted that normally a urinary catheter is changed monthly, and the frequency is usually written in the physician's orders.

On April 17, 2019, Inspector #178 interviewed RPN #116, who works full time on resident #003's unit. RPN #116 indicated that normally urinary catheters are changed monthly, this is usually ordered by the physician, and the order will appear on the electronic Medication Administration Record (eMAR). When asked why resident #003's catheter was not changed for five months when the resident's plan of care indicated it should be changed monthly, RPN #116 indicated that if the intervention did not show on the resident's eMAR, then the RPN may not remember the catheter needs to be changed.

Log #031553-18 [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that registered nursing staff was provided with training related to continence care and bowel management, on either an annual basis, or based on the staff's assessed training needs.

In accordance with sections 76 (7) 6 and 76 (5) of the Long Term Care Homes Act 2007, and sections 221 (1) 3 and 219 (1) of Ontario Regulation 79/10, the licensee is required to provide annual training in continence care and bowel management to all staff who provide direct care to residents.

Inspector #178 requested the 2018 and 2019 continence care and bowel management training records for four registered staff members working on an identified unit. Director of Care #108 provided the records for 2019, but indicated that in 2018 registered nursing staff of the home did not receive training in continence care and bowel management because the person responsible for providing the training had been off work for an extended period. Director of Care #108 indicated that the training needs of the four registered nursing staff members had not been assessed, and that the registered nursing staff members should have received the training annually. Review of the training records indicated that the four registered nursing staff members received the required training in 2019.

Log #031553-18 [s. 221. (1) 3.]

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 training in the area of continence care and bowel management to staff who provide direct care to residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

In accordance with O.Reg 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs, including skin and wound care, required under section 48 of the Regulation that included relevant policies and protocols to provide for methods to reduce risk and monitor outcomes.

Specifically, staff did not comply with the licensee's Skin Care and Wound Management policy, revised February 22, 2019.

While following up with Compliance Order #001 from inspection #2018_621547_0032, Inspector #732 reviewed the licensee's current Skin Care and Wound Management

policy provided by Director of Care #108. The policy indicates that each resident who exhibits skin breakdown and/or wounds shall be assessed each week or more frequently, if needed, by a member of the registered nursing staff and an assessment is to be completed weekly using Point Click Care (PCC) skin and wound module. Director of Care #108 and Assistant Director of Care #117 clarified that this skin and wound module is an assessment within PCC entitled Skin and Wound Evaluation.

Inspector #732 reviewed resident #007 electronic health record. Resident #007 has a specific diagnosis with complications that impact skin integrity. The resident suffers from a specific wound, and as indicated in resident #007's progress notes, has been slow to heal. Resident #007's electronic Medication Administration Record (eMAR) indicated that they were to have weekly wound assessments completed. As per the licensee's policy, these assessments were to be documented using the licensee's skin and wound module. Resident #007 had a documented skin and wound assessment on a specific date. The next documented skin and wound assessment was 14 days later though wound care in between these dates had been documented on the eMAR. Inspector #732 confirmed with Director of Care #108 and Assistant Director of Nursing #117 that a weekly would assessment was not documented according to policy for resident #007 in between the 14 days.

The licensee has failed to ensure that resident #007's weekly wound assessment was documented according to the licensee's Skin and Wound Management policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg. 79/10 s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that the policy for the medication management system, is complied with.

A Critical Incident Report which was submitted by the licensee indicated that a blister card containing four narcotic tablets went missing from the Emergency Narcotics Supply, and could not be found despite an extensive search. The Critical Incident Report indicated that the registered practical nurse who worked the shift before the missing narcotics were discovered, did not complete the end of shift count with oncoming registered nursing staff as per the home's policy.

On April 16, 2019, Director of Care #108 indicated to Inspector #178 that it is the home's policy and process that narcotics are counted at the beginning and end of each shift by the oncoming and outgoing registered nurse. Director of Care #108 indicated that on the date of the incident, RPN #120 did not count the narcotics with the oncoming registered nursing staff. Instead, two registered nursing staff from the on coming shift counted the narcotics together. It was at this point that it was discovered that a blister card containing four narcotic tablets was missing.

Log #015720-18 [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that with respect to the restraining of a resident by a physical device under section 31 of the act, that staff apply the physical device in accordance with any manufacturer's instructions.

A Critical Incident Report was submitted to the Director describing the unwitnessed fall of resident #011. The Critical Incident Report indicated that resident #011 removed their table top, attempted to stand unassisted, and fell; resulting in an injury.

Review of resident #011's electronic health care record indicated that while resident #011 is up in their chair, the use of a reverse table top as a physical restraint for the prevention of falls. When asked how a reverse table top works, Assistant Director of Nursing #117 and Director of Care #108 both explained that a reverse table top is applied to the resident's chair and then secured behind the chair with a clip. Director of Care #108 explained to Inspector #732 that staff need to ensure the clip is properly secured in order for the table top to be effective as a restraint and a falls prevention method. PSW #128 demonstrated to Inspector #732 how to properly apply resident #011's reverse table top. PSW #128 indicated that staff need to listen for a click to ensure that the clip behind the chair is properly secured.

In an interview, Director of Care #108 told Inspector #732, that although the staff member taking care of resident #011 on the date of the fall had told Director of Care #108 they had clipped the table top tray behind resident #011's chair, Director of Care #108 indicated that it must not have been clipped securely as resident #011 was able to push it off.

The licensee has failed to ensure that resident #011's reverse table top was properly applied as per manufacturer's instructions.

Log #028499-18 [s. 110. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On April 17, 2019, Inspector #178 observed the narcotic drawer of a unit medication cart. In addition to narcotics for the unit and the Contingency Medication Supply, the narcotic drawer also contained nine non-drug related items. The narcotic drawer contained numerous envelopes containing small amounts of money and labelled with residents' names, and also contained jewellery labelled as belonging to two residents, and a small stuffed toy. RPN #116, who was working on the unit at the time, indicated to Inspector #178 that these items were being stored in the narcotic drawer for safekeeping, until the residents needed their money, or the valuables could be sent home with the residents' families.

On April 18, 2019, Director of Care #108 indicated to Inspector #178 that the narcotic drawer tends to be used to lock items on the unit, but it is the expectation that only controlled substances should be stored in the narcotic drawer.

Log #015720-18 [s. 129. (1) (a)]

Issued on this 10th day of May, 2019

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

Original report signed by the inspector.