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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 30, 2019	2019_770178_0016	014995-19, 015124-19	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

SUSAN LUI (178)

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): August 27, 28, 29, 30, September 3, 2019.

Logs #014995-19 and #015124-19 were inspected regarding a complaint about resident care.

During the course of the inspection, the inspector(s) spoke with a resident, a resident's family, a Personal Support Worker (PSW), Registered Practical Nurses (RPNs), a Registered Nurse (RN), and the Director of Nursing (DON).

During the course of the inspection, the inspector also observed resident home areas and storage areas within the home, reviewed a resident's medical health record, reviewed correspondence between a family member and the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of resident #001's care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

This non compliance is in regards to Log #014995-19 and Log #015124-19.

Review of the medical health record indicated that resident #001 had a history of frequent specified infections.

Family member #112 indicated to Inspector #178 that on an identified date, resident #001 became ill from a specified infection. Family member #112 indicated the following: On an identified date, resident #001 was lethargic and had to be fed, which was very unusual for the resident who normally fed themselves. RPN #101 checked resident #001's vital signs and found their oxygen saturation (O2 sat) level was 88 %. Family Member #112 believed this was lower than it should be for resident #001 and asked if oxygen should be applied. RPN #101 indicated to the family member that they had called the physician and resident #001 would be started on antibiotics. Resident #001 became more lethargic and their O2 sats continued to decline, and the resident was transferred to hospital by the charge nurse on the next shift. Family Member #112 indicated that they later spoke to resident #001's physician who indicated that RPN #101 had not informed them about resident #001's low O2 sat or their needing to be fed their meal.

RPN #101 indicated to inspector #178 that resident #001 normally fed themselves, but on an identified date, the resident was just sitting and staring, so RPN #101 fed the resident their meal. RPN #101 indicated that they assessed the resident's vital signs and

found their oxygen saturation (O2 sat) level to be 89% and their temperature to be slightly elevated. RPN #101 also assessed the resident to be increasingly weak and described them as not themselves. RPN #101 contacted resident #001's physician and told them about resident #001's increasing weakness and the slightly elevated temperature but did not inform the physician that the resident required feeding and had an O2 sat of 89%. RPN #101 indicated to inspector #178 that they had had a prior conversation with resident #001's physician in the past, in which the physician told them that an O2 sat of 89 or 90% is adequate for resident #001. RPN #101 indicated to Inspector #178 that when they called the physician a few days after the most recent infection to clarify this direction, the physician did not remember the conversation and clarified to RPN #101 to apply oxygen for resident #001 if their O2 sat is less than 90%.

The DON indicated to Inspector #178 that when resident #001 became ill on an identified date, RPN #101 called the resident's physician, but did not inform the physician that resident #101's O2 sat was under 90% and that resident #001 needed to be fed their meal that day. The DON indicated that RPN #101 should have provided the physician with all the details of the resident #001's condition. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of resident #001's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing needs of resident #001.

This non compliance is in regards to Log #014995-19 and Log #015124-19.

Family member #112 indicated to Inspector #178 that on an identified date, resident #001 became ill from a specified infection and exhibited symptoms including shallow and rapid respirations, a low oxygen saturation reading, and lethargy to the extent that the resident had to be fed their meal, which was very unusual for this resident. Oxygen was not applied for resident #001 even though the resident's respirations were shallow and rapid. When paramedics arrived at close to 2000h, they asked why oxygen had not been applied and immediately applied it to resident #001. Family Member #112 overheard someone in the hall saying that they could not find oxygen and that it had been moved because the home had a new oxygen provider.

RN #111 indicated to Inspector #178 that on an identified date, RPN #100 called them to assess resident #001 who was not feeling well and was having difficulty breathing. RN #111 indicated that they assessed resident #001 and found they were short of breath and using abdominal muscles to breathe, had a low O2 sat reading and a fever. RN #111 indicated that they arranged for the resident to be transferred to hospital and they asked RPN #100 to apply oxygen, but RPN #100 told them there was no oxygen available on the unit. RN #111 indicated they called each unit in the home and could not find oxygen on any of the units or in the supply room on second floor. RN #111 indicated that paramedics arrived quickly and applied oxygen to resident #001 before transferring the resident to hospital. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing needs of residents, to be implemented voluntarily.

Issued on this 9th day of October, 2019

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

Original report signed by the inspector.