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_0017	007449-19, 010455-19, 011341-19	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

SUSAN LUI (178), MEGAN MACPHAIL (551)

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): August 27, 28, 29, 30, September 3, 4, 5, 6, 2019.

The following Logs were inspected:
 # 007449-19 and #011341-19 regarding alleged resident to resident abuse, #010455-19 regarding an allegation of visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, Personal Support Workers (PSWs), Registered Practical Nurses, Registered Nurses, the DON.

During the course of the inspection the inspectors also observed residents and resident care, reviewed resident health records, reviewed the home's policy to promote zero tolerance of abuse and neglect.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's plan of care was based on any mood and behaviour patterns, including wandering.

Resident #005 was admitted to the home approximately one year ago and ambulates on their own with the use of walker.

In interviews with PSW #114, PSW #116, PSW #117, RPN #118, RN #121 and the DON, they all stated that resident #005 wanders, and that the resident attempts to enter the rooms of female co-residents. Several staff members identified specific female residents whose rooms resident #005 has attempted to enter.

RN #121 and PSW #116 indicated that some female residents were fearful of resident #005. A progress note entry in resident #005's chart written by the physician on an identified date, indicated that residents on the floor did not feel protected from resident #005, and that this had been brought forward to the Residents' Council.

A review of progress notes indicated nine incidents of resident #005 wandering to female co-residents' rooms between November 2018 and August 2019.

Resident #005's written plan of care was not based on their tendency to wander into the rooms of co-residents who are female. [s. 26. (3) 5.]

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 resident #005's plan of care is based on any mood and behaviour patterns, including wandering, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

An allegation of resident to resident sexual abuse was reported to the Director on an identified date at 1650 hours when the After-Hours line was contacted.

The Critical Incident Report (CIR) was not amended to report the results of the abuse investigation to the Director. In an interview with the DON, they stated that it was thought that resident #005's behaviour was as result of medication that they were taking for Parkinson's that had caused bad side effects included nightmares, psychotic dreams and sleep walking. [s. 23. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The person who had reasonable grounds to suspect that the abuse of resident #006 by resident #005 did not immediately report the suspicion and the information upon which it was based to the Director.

The Director was informed of an allegation of resident to resident sexual abuse, under LTCHA, s. 24 (1), on an identified date at 1650 hours when the After-Hours Line was contacted. Critical Incident Report (CIR) C601-000009-19 was submitted on the same date.

According to the CIR, resident #010 reported that they saw resident #005 leave resident #006's room wearing only a t-shirt, and that urine was found around resident #006's bed and on their blanket.

According to a record review and interview with RN #121 who responded to the incident, this occurred at approximately 2300 hours on the day on before it was reported via the After-Hours Line and CIR C601-000009-19.

In a progress note written in resident #006's chart, RN #121 stated "Resident was further told by writer that entering other resident's room without permission and more so half naked is and abuse to the other resident".

In an interview with RN #121, they stated that following the incident, they left a voice message for either or both the DON and the Director of Social Work.

The Director was not immediately notified of the alleged abuse of resident #006 that occurred on an identified date at 2300 hours; the Director was not notified until the following day at 1650 hours. [s. 24. (1)]

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.