Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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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
Dec 2, 2019	2019_785732_0035	016936-19, 019989-19	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

EMILY BROOKS (732), MARK MCGILL (733)

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): November 18 - 22, 2019

Log #016936-19 related to improper/incompetent treatment of a resident, and log #019989-19 related to responsive behaviours was inspected in this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Nurses (RN's), a Registered Practical Nurse (RPN), and personal support workers (PSW's).

During the inspection, the inspector(s) observed the provision of care and services to residents, resident care areas, staff to resident interactions, and resident to resident interactions.

In addition, the inspectors reviewed resident health care records, investigation notes, and behvaiour monitoring charts.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #001’s plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director that described the improper transfer of resident #001 to the toilet by PSW #106. The CIR described that the resident sustained an injury to their lower extremity from a transfer to the toilet, using an incorrect lift. Furthermore, the CIR described that the resident’s care plan indicated they are to be transferred with a different lift, using two staff at all times, and that the resident was not to be toileted.

The responding staff to the incident was RPN #102. In an interview with Inspector #732, RPN #102 described PSW #103 and PSW student #107 coming to them in the nursing station, indicating that they needed to come immediately as resident #001 had sustained an injury to their lower extremity. RPN #102 described that resident #001 was assessed for an injury to their lower extremity and the RN in charge was called as they felt the injury may require hospitalization. Furthermore, RPN #102 told Inspector #732 that resident #001 is to use a specified lift for transfer and that PSW #106 had used a completely different lift. Investigation notes indicated that when RPN #102 arrived at resident #001’s room, the resident was in bed. In the investigation notes, RPN#102 described that the injury to resident #001’s lower extremity was severe. Progress notes indicated that resident #001 was sent to hospital and returned with a diagnosis of lower extremity injury and an order for dressing changes to the lower extremity.

Inspector reviewed investigation interview between PSW student #107 and management. In the interview, PSW student #107 indicated that they saw the call bell light on for resident #001’s room and an individual came calling that the resident was in bad shape.

PSW student #107 described that when they arrived in resident #001’s room, resident #001 was screaming and panicked. They were laying on the toilet, with their head against the wall. PSW student #107 indicated that PSW #106 was trying to lift resident #001 up with the wrong lift, moving it up and down. PSW student #107 then asked PSW #106 what they were doing as resident should not have been there. The interview indicated that PSW #106 had resident #001’s lower extremity up on the shin guard.

PSW #103 described the incident to Inspector #732 in an interview. PSW #103 stated that when they went into resident #001’s room they saw the resident sitting on the toilet, with the resident’s head leaning against the metal lever of the toilet. PSW #103 indicated that they rushed over to resident #001 to ensure they were ok, and informed inspector that resident #001 should not have been on the toilet. PSW #103 said they asked PSW #106, “why is resident #001 here? You know the resident is a specified lift”. PSW #103 indicated to Inspector #732 that the resident was in a specified lift and should not have been due to the resident's health care needs. PSW #103 then indicated that PSW #106, PSW student #107, and themselves, assisted resident #001 back to bed with the wrong lift at the request of PSW #106. PSW #103 told Inspector #732 that it was not until resident #001 was back in bed that the lower extremity injury was noticed.

Inspector #732 reviewed resident #001's care plan in use at the time of the incident. The care plan indicated that for transfers, resident #001 used a specified lift, indicating the size and colour; and to always use two staff. The care plan also indicated that resident #001 is not toileted. In an interview with ADOC #100, they indicated that at the time of the incident, PSW #106 had used the incorrect lift, alone, to transfer the resident and that the resident should not have been on the toilet. Therefore, care was not provided to resident #001 as specified in their plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in resident #001’s plan of care was documented.

A Critical Incident Report (CIR) was submitted to the Director that described the improper transfer of resident #001. The CIR described that the resident sustained an injury to their lower extremity from a transfer to the toilet using a specified lift. Furthermore, the CIR described that the resident’s care plan indicated they are to be transferred with a different lift, using two staff at all times, and that they are not toileted. Progress notes indicated that resident #001 was sent to hospital and returned with diagnosis of a lower extremity injury and an order for dressing changes to the lower extremity. Resident was to be seen for follow-up. Weekly wound assessments were initiated.

Review of resident #001’s electronic medication administration record (eMAR) indicated that on a specified date, resident #001 had an order to change dressing one time a day, every other day. On a different date, the order was changed and instructed to change wound dressing once daily. The order was discontinued at a later date. For a specified period of time, resident #001's dressing change had not been initialed on six separate dates.

On resident #001 eMAR there was also an order for weekly wound assessments, one time a day, every Thursday, that had been started on a specified date. The weekly wound assessment was not initialed for one specified date.

In an interview with RPN #102, they told Inspector #732 that they had completed the dressing changes and the wound assessment for the above dates. RPN #102 reviewed the eMAR from a specific time frame, and indicated that the interventions had not been documented.

As a complication of resident #001’s lower extremity injury, resident #001 developed two infections requiring antibiotics. Review of resident #001 eMAR indicated that resident #001 was prescribed an antibiotic,1 tablet orally, four times a day, for seven days. At a later date, resident #001 was also prescribed another antibiotic, two capsules orally, three times a day for 10 days. The antibiotics were not initialed as given on a specified date at 1200 hours, and on two separate specified dates at 1400 hours. RPN #107, who worked two out of the three dates, indicated that they had given the antibiotics to resident #001. RPN #102 reviewed the eMAR and indicated that the medications had not been documented as given.

Therefore, a weekly wound assessment, resident dressing changes, and administration of medications were not documented as set out in resident #001’s plan of care. [s. 6. (9) 1.]

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, to be implemented voluntarily.

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.