Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 7, 2020	2020_665551_0002	023043-19, 024047-19, 024476-19, 000717-20	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

MEGAN MACPHAIL (551)

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): January 13, 14, 17, 20, 21, 22 and 23, 2020.

The following logs were inspected:
023043-19 related to concerns about the care of a resident.
024047-19 related to concerns about the care of a resident.
024476-19 / Critical Incident Report C601-000026-19 related to an allegation of staff to resident neglect.
000717-20 related to concerns about the care of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, the Registered Dietitian (RD), the Scheduling and Staffing Co-ordinator, the Manager of Facilities and Environmental Services, the Director of Social Work, the Director of Nursing (DON) and the Chief Executive Officer (CEO).

During the course of the inspection, the inspector(s) reviewed health care records and selected policies and procedures, and made observations related to the provision of care to a resident and the functionality of a resident's resident-staff communication and response system.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Sufficient Staffing

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

4 WN(s)
3 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. 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 and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg 79/10, s. 68 (2) (d), the licensee was required to ensure that the nutrition care and hydration programs include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the licensee's policy titled Monitoring of Resident Nutritional Status (revision date: 04/01/2020) which is part of the licensee's Food & Nutrition Services 2020 program.

The Monitoring of Resident Nutritional Status procedure, under Food & Beverage Intake, directs the Health Care Aides to: observe and record meal and fluid intake on Point of Care (POC) section of Point Click Care (PCC). Health Care Aides notify RN and RPN's of any food or fluid intake or swallowing concerns; and RN informs dietitian of any residents with nutritional concerns by leaving a phone message and filling out the Dietitian Referral form with the date, resident name and details of the nutritional concern.

A review of resident #001's food and fluid intakes for a specified period of time indicated that the resident consumed most or all of the meal, the majority of the time, and consumed a specified amount of fluids per day. Commencing on a specified date, the resident's intake of solids and liquids declined.

The Monitoring of Resident Nutritional Status policy was not complied with when, as confirmed by the RD, they did not receive a referral to address the nutritional concern when resident #001's intake of solids and liquids declined. [s. 8. (1) (a),s. 8. (1) (b)]

2. Staff did not comply with the licensee's policy titled Monitoring of Resident Nutritional Status (revision date: 04/01/2020) which is part of the licensee's Food & Nutrition Services 2020 program.

The Monitoring of Resident Nutritional Status procedure, under Food & Beverage Intake directs the Health Care Aides to: observe and record meal and fluid intake on POC section of PCC.

The Monitoring of Resident Nutritional Status policy was not complied with when meal intakes for residents #001, #002 and #003 were not recorded on the POC section of PCC on specified dates. [s. 8. (1) (a),s. 8. (1) (b)]

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 licensee's policy titled Monitoring of Resident Nutritional Status (revision date: 04/01/2020) which is part of the licensee's Food & Nutrition Services 2020 program is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's weight change was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

Between specified dates, resident #001 experienced a weight change.

In an interview with the RD, they indicated that in addition to the quarterly assessment, it was up to the RD to monitor residents more frequently. The RD stated that any assessment completed in between the quarterly assessment would be documented in a progress note.

The resident's weight change was not assessed using an interdisciplinary approach and actions were not taken. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug was administered to resident #002 in accordance with the directions for use specified by the prescriber.

On a specified date, resident #002's physician ordered that a specific medication be administered at specific intervals.

A review of the resident's electronic Medication Administration Record (eMAR) indicated that a dose of the medication was administered to resident #002 on a specified date. A review of resident #002's eMARs indicated that the medication was not administered at an interval specified by the resident's physician.

In an interview with the DON, they stated that the medication was not administered at the intervals as prescribed by the physician. [s. 131. (2)]

2. The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

According to Physician's Order Reviews for authorized periods of time, and signed by the physician on specified dates, resident #001 was ordered several medications that were given on a regular basis and medications given on an as needed basis.

A review of resident #001’s health care record for a specified period of time indicated that as needed medications to manage a specific condition were not administered to resident #001 as directed by the physician on several occasions.

As needed medications were not administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to resident #002 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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 care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complimented each other.

On a specified date, resident #001 was readmitted to the home from a medical leave. On the same day, the resident returned to acute care, and according to documentation, the resident's substitute decision-makers (SDMs) agreed to this transfer.

Several hours later, the resident was returned to the home. The resident was not readmitted to the home and was sent back to the hospital. Documentation from an Emergency Room Physician indicated that they had been trying to contact the home's management with no results.

The licensee's staff did not collaborate with the staff at the hospital when the resident returned from hospital, was not readmitted to the home, and RN #115 who was on duty did not attempt to communicate with the hospital. [s. 6. (4) (a)]

Issued on this 11th day of February, 2020

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

Original report signed by the inspector.