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

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
Jun 18, 2021	2021_770178_0011	006449-21	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): May 20-21, 25-28, 31, June 1-3, 9-10, 15-16, 2021.

The following intake was completed in this complaint inspection:
Log #006449-21 was related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC)/Infection Prevention and Control (IPAC) Lead, Assistant Director of Care (ADOC), Registered Nurses (RNs), Student RN, Registered Practical Nurses (RPNs), Student RPN, Personal Support Workers (PSWs), Covid-19 Screener, a resident, and the family of a resident.

During the course of the inspection the inspector observed infection prevention and control practices, observed medication administration practices, and reviewed clinical health records and other pertinent documents.

Inspector #705004 was also present during this inspection.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident unless the drug was prescribed for the resident.

A resident was administered a medication that was not prescribed for the resident. The medication was meant for another resident with a similar name, and was administered to the resident in error.

Sources: The Medication Incident Report and the clinical health record for a resident; interviews with an RN, Student RN, and the ADOC. [s. 131. (1)]

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

On three occasions, a topical medication was administered to a resident in a manner which was not in accordance with the directions for use specified by the prescriber.

Sources: Observation/review of medication administration; clinical health records for a resident; interviews with an RPN and a Student RPN. [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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

The DOC indicated that it is the home's policy that all staff wear eye protection whenever they are within two metres of a resident.

Two RPNs and a PSW provided care within two metres of a resident indoors while not wearing appropriate eye protection (e.g., goggles or face shield). When interviewed, the staff members indicated that they were aware of the requirement to wear eye protection when within two metres of a resident, but they sometimes do not wear it because the goggles and face shield cause discomfort and impair their vision.

Sources: Observation/review of IPAC practices; interviews with RPNs, a PSW, and the DOC. [s. 229. (4)]

2. An RPN found three to five vaginal applicators stored loosely in the medication cart without any indication of which resident or vaginal cream the applicators had been used for. The RPN washed the vaginal applicators with hot soapy water, wiped them with alcohol swabs, and placed them in boxes with the vaginal creams of two residents without knowing whether these applicators had been previously used for other residents.

The ADOC indicated that a vaginal applicator used to administer a resident’s vaginal cream should be used for only one resident, washed with warm soapy water after each use, and stored in the box with the individual resident’s vaginal cream.

Sources: Interviews with an RPN and the ADOC. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 12th day of July, 2021

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

Original report signed by the inspector.