Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Amended Public Report (A1)

Report Issue Date: January 5, 2023	
Inspection Number: 2022-1523-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: The Ottawa Jewish Home for the Aged	
Long Term Care Home and City: Hillel Lodge, Ottawa	
Inspector who Amended Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.01.27 10:11:44 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 17-21, 24-28, and 31, 2022 and November 3, 2022

The following intake(s) were completed in this complaint inspection:

Intake #00001403 was related to fall prevention, pain management, prevention of abuse/neglect and reporting;
Intake #00001701 was related to continence care, reporting and transferring; and
Intakes #00006428 and 00009197 were related to fall prevention, medication/pain management, care and support services, resident rights, nutrition/hydration and continence care.

The following intake(s) were completed in this Critical Incident System (CIS) inspection:

Intake #00002227, CIS#3029-000012-22 and Intake #00002450, CIS#3029-000007-22 were related to responsive behaviours, prevention of abuse/neglect and reporting;
Intake #00002342, CIS#3029-000005-22 was related to safe and secure home;
Intake # 00005177, CIS#3029-000004-22, Intake #00005199, CIS#3029-000014-22 and Intake #00005786 CIS#3029-000013-22 were related to fall prevention; and
Intake #00007392, CIS#3029-000017-22 was related to care and support services and fall prevention;
Intake #00009001, CIS#3029-000018-22 was related to fall prevention, pain management, and reporting.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Pain Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Residents' Rights and Choices
Responsive Behaviours
Safe and Secure Home

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been revised to reflect an extension of six weeks to the compliance due date. The Complaint and Critical Incident System inspection, inspection #2022-1523-0001 was completed on October 17-21, 24-28, and 31, 2022 and November 3, 2022

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

A resident's plan of care stated the resident is to receive physiotherapy three times weekly. The Physiotherapist stated in October, that resident receives physiotherapy two to three times weekly and recently only twice a week.

The unclear directions related to the resident's physiotherapy frequency caused a low risk to the resident. In October 2022, the plan of care was changed and there were clear directions to provide the resident physiotherapy two to three times weekly.
[755]

Date Remedy Implemented: October 28, 2022

WRITTEN NOTIFICATION: Reports re critical incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (4) (a)

The licensee has failed to ensure that the hospital was contacted within three (3) calendar days after a resident's fall to determine whether the injury had resulted in a significant change in the resident's health condition.

Rationale and Summary

A resident fell and was sent to hospital.

The DOC stated that the hospital was not contacted within three (3) calendar days after the resident's fall. They stated that they were informed by the resident's family member six (6) days after the fall that the resident had suffered a significant injury as a result of the fall. The Critical Incident Report was then submitted eight (8) days after the resident's fall to report an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Sources: Interview with the DOC and the Critical Incident Report.

[551]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

A person who had reasonable grounds to suspect resident abuse by another resident that resulted in harm or risk of harm failed to immediately report the suspicion and information upon which it was based to the Director.

Rationale and Summary

In May 2022, a resident was found by a staff member in another resident's room, exhibiting inappropriate behaviour towards the other resident. The critical incident (CIS) was submitted for the first time two days after the incident occurred.

The Director of Care (DOC) confirmed that the CIS was submitted late.

Sources: CIS and interview with DOC.

[720492]

WRITTEN NOTIFICATION: Police notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 105

The licensee failed to ensure the appropriate police force was immediately notified of an alleged incident of resident to resident abuse.

Rationale and Summary

In May 2022, a resident was found by a staff member in another resident's room, exhibiting inappropriate behaviour towards the other resident. The police were not immediately notified of this alleged incident of abuse. The DOC confirmed that they were contacted two days after the incident occurred. Failing to immediately notify the police of alleged incidents of abuse places residents at risk of harm.

Sources: CIS and interview with DOC.

[720492]

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3.

The licensee failed to respond to the written complaint made by the complainant related to the care of a resident as required.

Rationale and Summary

The LTCH received a letter of complaint that outlined concerns related to the care of a resident.

The Administrator stated that the complainant was responded to by email on the same day. The response was reviewed and failed to include what the licensee has done to resolve the complaint including confirmation that the licensee would immediately forward the complaint to the Director, as the letter contained an allegation of resident neglect. The Administrator confirmed that no further written correspondence or follow up was made to the complainant after the initial email.

Sources: Complaint response email and interview with the Administrator.

[720492]

WRITTEN NOTIFICATION: Complaints — reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 111 (1)

The licensee failed to submit a copy of a written complaint related to alleged neglect of a resident to the Director along with a written report documenting the response the licensee made to the complainant.

Rationale and Summary

The LTCH received a letter of complaint that outlined concerns related to potential neglect of a

resident. The Administrator confirmed that this written complaint was not reported to the Director.

Sources: Complaint email and interview with the Administrator.

[720492]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Rationale and Summary

Inspector reviewed a video for a resident. In the video, it was noted that during the resident's transfer, the resident's lower body was not positioned properly in the transfer sling. The resident was not transferred properly by two PSWs, due to the improper application of the transfer sling.

Inspector reviewed the video footage with the DOC. During the interview, the DOC indicated that it was an unsafe transfer as the resident was not positioned correctly in the transfer sling.

Sources: Video recording and interview with the DOC.

[740864]

WRITTEN NOTIFICATION: Pain management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 57 (1)

The licensee has failed to ensure that the Pain Management program provided strategies to manage pain for a resident.

Rationale and Summary

A resident had a fall. They were assessed by a Registered Practical Nurse (RPN) who noted that the resident could not weight bear appropriately. The on-call physician was contacted, and an ambulance was called. The resident suffered an injury as a result of the fall.

The RPN stated that the resident cried and grimaced when their ability to weight bear was tested and at times when waiting for the ambulance.

A PSW documented the resident's pain as "Hurts a Whole Lot".

Resident was ordered pain medication. The RPN stated that the resident had received their pain medication dose approximately fifteen (15) minutes before the fall, and no other pain medication was administered after the fall despite complaints of pain by resident. During a second call to the on-call physician, while the resident was waiting for the ambulance, the RPN did not request to administer a pain medication to the resident. The resident was seated for approximately two and a half hours after the fall before they departed for hospital.

The resident complained of pain post fall, and no effective strategies to manage their pain were implemented.

The DOC stated that the resident should have been given a medication for pain after they fell and complained of pain.

Sources: Resident's health care record and interviews with RPN and the DOC.

[551]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O.Reg. 246/22, s. 102 (2) (b)

The licensee shall:

1) Perform weekly audits to ensure that staff are following the licensee's Infection and Prevention Program with regards to:
Proper use of personal protective equipment (PPE) when interacting with residents on Additional Precautions, including the use of Droplet and Contact Precautions, ensuring appropriate application, removal, and disposal of PPE.
The audits are to be conducted until consistent compliance to the Infection and Prevention Program described above is demonstrated.

2) Take corrective actions to address staff non-compliance to the licensee's Infection Prevention and Control program identified in the audits.
Records of the audits and corrective actions taken to address staff non-compliance to the licensee's Infection Prevention and Control program shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that where the Director issues any standard or protocol with respect to Infection Prevention and Control (IPAC), the policy directives were complied with.
As per O. Reg 246/22, s. 102 (2) (b), the Licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

In accordance with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes, the licensee was required to ensure that the personal protective equipment requirements as set out in the COVID-19 Guidance: Long-Term Care Homes and Retirement Homes for Public Health Units were followed.

The Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes (Version 8 – October 6, 2022) specified that for COVID-19, appropriate Additional Precautions includes the use of Droplet and Contact Precautions.

In accordance with the Infection Prevention and Control Standard for Long-Term Care Homes, Additional Precautions requirement 9.1 (f), must be followed and include, at a minimum, appropriate personal protective equipment (PPE) application, removal and disposal.

Additionally, Public Health Ontario's Routine Practices and Additional Precautions for management of COVID-19 for health care workers specified:
Visitors to wear a mask, eye protection, gown and gloves when entering the room of a patient with

COVID-19.

#1

Rationale and Summary

Registered Nurse (RN) stated that a resident was COVID-19 positive and under isolation with Droplet and Contact Precautions in place.

The resident's sitter was in the resident's room and was not wearing a gown. After a few minutes, the sitter donned a gown and began to feed the resident.
Droplet and contact precautions were posted on the resident's door.

The unit where resident resided was on a COVID-19 outbreak and an ARI outbreak. The absence of a gown meant that Droplet and Contact Precautions were not followed, increasing the risk of viral transmission.

Sources: Inspector observations and Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes (Version 8 – October 6, 2022).

[551]

#2

Rationale and Summary

An agency Registered Practical Nurse (RPN) entered and exited a resident's room without donning appropriate personal protective equipment (PPE). The RPN confirmed that the resident was COVID-19 positive and under isolation with Droplet and Contact Precautions in place and signage posted on the door.
The unit where the resident resided was on a COVID-19 outbreak. The absence of a gown meant that Droplet and Contact Precautions were not followed, increasing the risk of viral transmission.

The IPAC Lead confirmed that all staff, including agency staff are trained about appropriate PPE usage when interacting with residents on isolation and that all staff are required to follow PPE guidelines while in the home.

Sources: Inspector observations, Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes (Version 8 – October 6, 2022), and interview with IPAC Lead.

[720492]

#3

Rationale and Summary

On a COVID-19 outbreak unit, thirteen (13) residents were on Droplet and Contact Precautions for confirmed or suspected cases of COVID-19. At the lunch meal, PSWs went room to room, including rooms that were on Droplet and Contact Precautions, delivering beverages and meals. The PSWs were not wearing a gown or gloves.

In an interview with Inspector #720492, the IPAC Lead stated that the PSWs should be donning and doffing PPE in between residents and serving the residents who did not have COVID-19 before serving the residents who were COVID-19 positive.

Sources: Interview with the IPAC Lead, inspector observations and Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes (Version 8 – October 6, 2022).

[551]

#4

Rationale and Summary

Two staff members were observed providing direct care to a resident who was on contact precautions. Staff were observed wearing mask, gloves, and eye protection at time of interaction with the resident. Staff were not wearing a gown.

Contact precautions signage on resident's door required staff to wear a gown, gloves, and eye protection while providing care or interacting with resident.

DOC confirmed that the resident was on contact precautions.

IPAC Lead and DOC confirmed that these staff completed the PPE training and are aware of the requirement for appropriate use of PPE while providing direct care to residents.

Sources: Observations of staff interaction with residents on unit and Interview with IPAC Lead and DOC.

[720492]

This order must be complied with by March 17, 2023

COMPLIANCE ORDER CO #002 Falls prevention and management

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 53 (1) 1.

The licensee shall:

1) Perform weekly audits to ensure that staff are following the licensee's falls prevention and management policies with regards to:

Completing a falls risk assessment using the licensee's post-fall assessment instrument, as per the Falls Prevention and Management policy.

Completing head injury routine using the licensee's head injury routine, as per the Falls Prevention and Management policy.

The audits are to be conducted until consistent compliance to the licensee's falls prevention policies described above is demonstrated.

2) Take corrective actions to address staff non-compliance to the licensee's fall prevention policies identified in the audits.
Records of the audits and corrective actions taken to address staff non-compliance to the licensee's falls prevention and management policies shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for three (3) residents.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention and Management", dated May 24, 2022, which was included in the licensee's Falls Prevention and Management Program.

The Falls Prevention and Management policy directed that post fall, the Registered Nurse will: Initiate Head Injury routine (HIR) and assess the resident's level of consciousness and any potential injury associated with the fall, do orthostatic blood pressure and a falls risk assessment. #7 directed to monitor the resident for 48 hours after a fall if they are on blood thinners.

The falls risk assessment directed staff to provide a description of the incident, injuries, pain, consciousness, predisposing factors, witnesses, notifications, progress notes and to complete triggered assessments.

Head Injury Routine V2 directs the RN/RPN to complete a Glasgow Coma Scale assessment at specific intervals.

#1

Rationale and Summary

A resident, who was prescribed a medication that may increase the risk of head injury complications, had a fall. They were transferred to hospital and suffered a significant injury as a result of the fall.

The resident fell and was transferred to hospital two and a half hours later. HIR was not initiated, and every hour interval checks and a falls risk assessment were not completed.

The RPN, who assessed the resident after the fall, stated that a falls risk assessment was not completed, and HIR was not initiated because the resident was being sent to hospital.

The resident was prescribed a medication that may increase the risk of head injury complications and was not monitored for a possible head injury as per head injury routine, between the time of the fall and their transfer to hospital. By not completing a falls risk assessment, factors that may have contributed to the fall were not investigated, and the fall was not captured in the home's Risk Management.

Sources: Falls Prevention and Management policy (May 24, 2022), resident's health care record and interview with the RPN.

[551]

#2

Rationale and Summary

A resident who was prescribed a medication that may increase the risk of head injury complications, was found on the floor. Swelling was found to the back of their head. HIR was initiated.

The second hourly check of the HIR was not performed.

Approximately twelve (12) hours later, the resident was found on the floor, face down. The resident sustained injuries, which were documented several hours later.

HIR checks at the prescribed intervals between the time of the fall and three (3) hours later were not completed. An additional HIR check was performed, after which the resident did not receive any further HIR checks at the prescribed intervals.

The next day after the fall, at breakfast, the resident seemed confused, was having difficulty drinking coffee and complained of nausea. After the resident experienced vomiting, they were sent to hospital and diagnosed with a significant change in their health condition.

The resident fell and hit their head twice in approximately 12 hours. The resident who was prescribed a medication that may increase the risk of head injury complications was not monitored for a possible head injury as per head injury routine, and they suffered a significant change in their health condition.

RAI Coordinator stated that HIR was not completed at the prescribed intervals after the residents falls.

Sources: Falls Prevention and Management policy (May 24, 2022), resident's health care record and

interview with RAI Coordinator.

[551]

#3

Rationale and Summary

A resident had an unwitnessed fall that resulted in a transfer to hospital resulting in a significant change in health status.

A review of the resident's medication administration record (MAR) confirmed that resident was prescribed a medication that may increase the risk of head injury complications.

A review of the resident's health care records confirmed that no post fall head injury routine or post fall risk assessment or monitoring related to the resident's prescribed medication that may increase the risk of head injury complications were found for resident's fall.

RAI Coordinator confirmed that a falls risk assessment was not completed, and head injury routine was not initiated at the time of the fall for the resident.

Sources: Fall Prevention and Management Policy "(Reference Code: Nursing 2021/FPM, Revision: 05/24/2022), resident health care record and interview with RAI Coordinator.

[720492]

This order must be complied with by March 17, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.

(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.