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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Original Public Report

Report Issue Date: May 25, 2023

Inspection Number: 2023-1523-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: The Ottawa Jewish Home for the Aged

Long Term Care Home and City: Hillel Lodge, Ottawa

Lead Inspector	**Inspector Digital Signature**
Megan MacPhail (551)	Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2023.06.01 09:36:25 -04'00'

Additional Inspector(s)
Lisa Cummings (756)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 5, 6, 11, 12, 13 and 14, 2023.
The inspection occurred offsite on the following date(s): May 1, 2, 3, 2023.

The following intake(s) were inspected:

- Intake #00013417 and #00022218 were related to concerns about the care of a resident.
- Intake #00017606 was a follow-up to compliance order #001, issued under O. Reg 246/22, s. 102 (2) (b) with a compliance due date of March 17, 2023.
- Intake #00017607 was a follow-up to compliance order #002, issued under O. Reg 246/22, s. 53 (1) 1. with a compliance due date of March 17, 2023.
- Intake #00020441 / 3029-000006-23 was related to a fall resulting in an injury and significant change in the resident's health condition.
- Intake #00084851 / 3029-000009-23 was related to reporting and complaints.

- Inspector #000721 and #000723 participated in this inspection as observers.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1523-0001 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Megan MacPhail (551)

Order #002 from Inspection #2022-1523-0001 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Megan MacPhail (551)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Reporting and Complaints
Pain Management
Falls Prevention and Management

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)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied

with.

In accordance with the Minister's Directive titled the Infection Prevention and Control (IPAC) Standard, the licensee was required to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, including point-of-care signage indicating that enhanced IPAC control measures were in place.

Rationale and Summary

A yellow door hanger with personal protective equipment (PPE) was placed on the doors of several resident rooms. There was no point-of-care signage indicating that enhanced IPAC control measures were in place.

An RPN stated that there were residents on isolation with droplet-contact precautions in place. The RPN stated that they were waiting for the signage to be provided as they had run out. The RPN photocopied droplet-contact signage and posted it on the doors of the rooms where it had been missing.

Sources: Interview an RPN and observations of the inspector.

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Date Remedy Implemented: April 11, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident had moisturizing lotion applied twice daily as specified in the plan of care.

Rationale and Summary

A resident had a physician's order for moisturizing lotion to be applied twice daily and as needed which was added to the treatment administration record (TAR). Registered Practical Nurses (RPNs) stated that they sign the TAR indicating that the moisturizing lotion was applied, however it is the Personal Support Workers (PSWs) who applied the moisturizing lotion. A PSW who provided care to the resident stated they did not apply moisturizing lotion each day. The PSW stated they would only apply the lotion if they noted dry areas, and that moisturizing lotion was most often applied after bathing. Failure to apply the moisturizing lotion twice a day increased the risk of the resident experiencing dry skin.

The DOC confirmed that the moisturizing lotion should be applied twice daily.

Sources: Physician orders, TAR documentation, Point of Care documentation, interviews with a PSW, RPNs and the DOC.

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WRITTEN NOTIFICATION: Complaints Procedure - licensee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to immediately forward to the Director a written complaint that they received concerning the care of a resident

Rationale and Summary

A resident's family member sent a written complaint to the Administrator by email. The email outlined concerns about the care of the resident.

The Administrator responded to the complainant on the same day and copied the Director of Care (DOC) and the Director of Professional Practice in their response.

The written complaint was forwarded to the Director using the Critical Incident System (CIS) electronic platform approximately one week after it was received.

The DOC stated that the written complaint should have been immediately forwarded to the Director.

Sources: A CIS report and interview with the DOC.

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WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was 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.

#1. Rationale and Summary

Specifically, staff did not comply with the Post Fall Management procedure, which was included in the licensee's Falls Prevention and Management Program and in effect when the resident fell.

The Falls Prevention and Management policy directed, under section C. Post Fall Management, the Registered Nurse to:
#1. 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 under "Actions" in Point Click Care for a post-fall risk assessment.
#5. Review fall prevention interventions and modify the plan of care as indicated.
#7. Monitor the resident for 48 hours after a fall if they are on blood thinners.

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

A resident, who was ordered a blood thinner, was found on the floor. As per a progress note, the resident was assessed for injury and vital signs were taken.

The RN who worked the subsequent shift wrote a progress note and indicated that the resident was monitored, and their vital signs were stable.

After the RN's note, there was no further documentation to indicate that the resident was monitored or assessed post-fall.

The Manager of Nursing Programs reviewed the resident's chart and stated that after the resident's fall, a Post-Fall Assessment and HIR were not completed, and the care plan was not reviewed and revised.

The resident's level of consciousness and any potential injury associated with the fall were not assessed and monitored post-fall as per policy. Fall prevention interventions were not reviewed and revised.

Sources: A resident's health care record, Post-Fall Management procedure (May 2022) and interview with the Manager of Nursing Programs.

#2. Rationale and Summary

Specifically, staff did not comply with the Post Fall Management procedure, which was included in the licensee's Falls Prevention and Management Program and in effect when the resident fell.

Specifically, staff did not comply with the Post-Fall Clinical Pathway (appendix 5) and completion of the Post-Fall Assessment Tool (appendix 7).

The Post-Fall Clinical Pathway directed that after a focused assessment by the first registered staff person on the scene, a clinical decision was made by registered staff to: not move the resident, move the resident using mechanical lift (following assessment by nurse and approval for transfer) or the resident gets up independently.

A resident was found on the floor by a PSW. They alerted the RN who assessed the resident.

As per the PSW, after the nurse's assessment, the resident was physically lifted off the floor by staff members, and the mechanical lift was not used as directed by the Post-Fall Clinical Pathway.

A Post-Fall Assessment Tool was partially completed and identified factors that contributed to the fall. Several sections of the Post-Fall Assessment Tool were left blank.

The resident later complained of pain. They were sent to hospital and diagnosed with an injury.

The Falls Prevention and Management policy was not complied with. The Post-Fall Clinical Pathway directed staff to use a mechanical lift to move a resident after a fall, following the nurse's assessment and approval for transfer. The Post-Fall Assessment Tool was partially completed and did not show that the circumstances of the fall were investigated in order to implement interventions to mitigate future falls and risk of injury.

Sources: A resident's health care record, Post-Fall Management procedure (January 2023) and interview with the Manager of Nursing Programs.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry

out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive titled the IPAC Standard, the licensee was required to ensure that Routine Practices and Additional Precautions were followed in the IPAC program, including proper use of PPE.

Rationale and Summary

A resident was isolated with droplet-contact precautions in place.

At the lunch meal service, a PSW was observed assisting the resident to eat their meal. The PSW was not wearing eye protection.

An RPN stated that the PSW should have been wearing eye protection as the resident had droplet-contact precautions in place.

Not wearing proper PPE meant that viral transmission may have occurred.

Sources: Interview with an RPN and observations of the inspector.

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that immediate action was taken to reduce transmission and isolate residents when there were symptoms indicating the presence of infection.

Rationale and Summary

On an evening shift, a resident had symptoms indicating the presence of infection. The following day, after more symptoms were displayed, a diagnostic test was performed and isolation was implemented.

On a night shift, a resident had symptoms indicating the presence of infection. The following day, a diagnostic test was performed and isolation was implemented.

On a night shift, isolation was implemented for a resident who was the close contact of a resident who was symptomatic.

The IPAC Lead stated that with the onset of new symptoms, there was a specific process to follow. The IPAC Lead stated that residents should have been tested and isolated with the onset of their symptoms, and that the resident who was a close contact should have been isolated at the same time.

Not taking immediate action to reduce transmission and isolate residents when there were symptoms indicating the presence of infection meant that viral transmission may have occurred.

Sources: Residents health care records, the Unit Daily Record report and interview with the IPAC Lead.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

The licensee has failed to ensure that the Director was informed of an incident in the home, that resulted in a significant change in the resident's health condition, no later than three business days after the occurrence of the incident.

Rationale and Summary

A resident was found on the floor. They were later sent to the hospital due to complaints of pain.

The licensee was aware that the fall had resulted in a significant change in the resident's health condition.

The CIS report was submitted later than three business days after the occurrence of the incident.

Sources: A CIS report and a resident's health care record.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.

The licensee has failed to ensure that the CIS report submitted to the Director, as required under O. Reg 246/22, s. 115 (5) subsection (4), set out the correct name of any staff members or other persons who were present at or discovered the incident.

A CIS report was submitted to the Director, and it identified a PSW as the staff who discovered the incident.

The PSW stated that they were not working the day of the incident. The Scheduling Co-ordinator confirmed that the PSW was not working and could not have been the staff who discovered the incident.

Sources: A CIS report and interview with the Scheduling Co-ordinator.

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WRITTEN NOTIFICATION: Requirements Relating to Restraining by a Physical Device

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.

The licensee has failed to ensure that, with respect to the restraining of a resident by a physical device under section 35 of the Act, staff applied the device in accordance with any manufacturer's instructions.

Rationale and Summary

A resident was ordered a restraint. The resident was unable to physically and cognitively release the physical device.

The manufacturer’s instructions provided specific guidance on how to apply the restraint.

The resident was observed with the restraint improperly applied.

Failure to follow the manufacturer's instructions could result in an injury to the resident.

Sources: Observations of the inspector and manufacturer's instructions.

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WRITTEN NOTIFICATION: Medication Management System

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to comply with the procedure to safely handle and dispose of sharps.

Rationale and Summary

In accordance with O. 246/22, s. 11 (1) (b) , the licensee is required to ensure that written policies and protocols, for the medication management system, are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and they must be complied with.

Specifically staff did not comply with the Safe Handling and Disposal of Sharps and Medical Waste (reviewed 04/01/2023), which was included in the licensee's medication management system.

A syringe was observed in a resident's room. The syringe was unlabelled, and the safety cap was covering the needle.

An RPN identified who the needle belonged to and stated that they had not administered any medications to the resident in their room that day. The resident was ordered intramuscularly injected (IM) medications regularly and as needed.

The RPN stated that the syringe should have been disposed of and removed it from the room.

The Safe Handling and Disposal of Sharps and Medical Waste stated that a syringe with needle attached was to be disposed in the sharps container.

Not properly disposing of a syringe meant that a resident could potentially be exposed to a sharp.

Sources: Interview with an RPN and policy titled Safe Handling and Disposal of Sharps and Medical Waste.

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