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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 01, 2023

Inspection Number: 2023-1523-0005

Inspection Type:
Complaint
Critical Incident

Licensee: The Ottawa Jewish Home for the Aged

Long-Term Care Home and City: Hillel Lodge, Ottawa

Lead Inspector	**Inspector Digital Signature**
Anandraj Natarajan (573)	Anandraj (Andy) Natarajan Digitally signed by Anandraj (Andy) Natarajan Date: 2023.09.05 15:29:12 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 24, 25, 28, 29, and 30, 2023.

The following intake(s) were inspected:

- Intake: #00016232 - Complaint /concerns related to care and services to the resident.
- Intake: #00011272 - 3029-000020-22: related to COVID Outbreak.
- Intake: #00092691 - 3029-000020-23: Allegations of a visitor to resident sexual abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the Minister's Directive, COVID-19 Response Measures for Long-Term Care Homes, effective August 2022 was followed by staff related to the Masking and Personal Protective Equipment (PPE).

Rationale and Summary: The Minister's Directive indicated that licensees were required to ensure that the requirements set out in the Ministry of Long-Term Care COVID-19 guidance document for Long-Term Care Homes in Ontario were followed. The Ministry of Health COVID-19 guidance document for Public Health Units: Long-Term Care Homes (LTCH), Version 11 – June 26, 2023, under Masking and Personal Protective Equipment (PPE): Recommended guidance related to PPE use for providing direct care to a resident with suspect or confirmed COVID-19. Additionally, guided with the PPE use for interacting within two meters of residents in an outbreak area.

On August 28, 2023, the inspector was informed by the IPAC lead that the home units in the LTCH were on a COVID-19 outbreak. The IPAC lead indicated to the inspector that the expectation was for the staff to wear N95 masks and eye protection (PPE) in the outbreak area as recommended by the local public health unit.

On August 28, 2023, during an observation of a home unit that was on the outbreak, the inspector observed staff members within proximity to the residents with no eye protection (goggles, face shield, or safety glasses with side protection). The inspector observed a PSW staff interacting within two meters of a resident who had lowered their mask under their chin and had no eye protection. The inspector observed external service care provider staff exited the resident's room with droplet and contact precautions with no protective gown.

On August 29, 2023, in an outbreak home unit, the inspector observed a PSW and housekeeping staff with no mask and eye protection in the residents' area (Hallway).

On August 30, 2023, in the outbreak home unit, the inspector observed a PSW staff with no eye protection exiting a resident's room after providing care to the resident. The inspector observed a staff member in a resident's room, not wearing a mask and eye protection. An RPN was observed wearing a double surgical mask on the unit.

Staff failing to follow the Ministry of Long-Term Care COVID-19 guidance documents related to Masking and PPE in an outbreak area increases the risk of disease transmission among residents, staff, and others.

Sources: Observations on the home units and interview with the IPAC lead Nurse. [573]