Ontario

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

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

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

Original Public Report

Report Issue Date: November 3, 2023	
Inspection Number: 2023-1523-0006	
Inspection Type: Complaint Critical Incident	
Licensee: The Ottawa Jewish Home for the Aged	
Long Term Care Home and City: Hillel Lodge, Ottawa	
Lead Inspector Julienne NgoNloga (502)	**Inspector Digital Signature**
Additional Inspector(s) Linda Harkins (126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3, 4, 5, 6, 10, 12, 13, 16, 2023.

The following intake(s) were inspected:

- Intake: #00095557 - (CIS #3029-000023-23) related to alleged resident to resident abuse.
- Intake: #00096153 - (CIS #3029-000024-23) related to a fall of a resident resulting in an injury.

Complaint

- Intake: #00096887 - related to an altered skin integrity with unknown cause.
- Intake: #00097896 -related to an alleged neglect of a resident.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 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 the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A resident's progress notes indicated that a day in August 2023, the resident had a fall which resulted in an injury. The resident’s plan of care indicated that they required two staff total assistance for bed mobility. The Document Survey Report (DSR) during all shifts for two weeks period showed that the resident was assisted by one staff during bed mobility.

In an interview, a staff member stated that before the resident had a fall with injury, they were assisting the resident in bed without assistance of any other staff.

By not following the resident's plan of care, the resident was at risk of injury when one staff assisted them with bed mobility.

Sources: Resident’s health record. Interview with staff. [502]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 24, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

As per the home's Zero Tolerance of Abuse and Neglect, revised 07/22, under 5.0 1.0 PROCEDURE:

A) Mandatory Reporting : A person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Administrator, Director of Care, or designate in charge of the home.

Specifically, an identified abuse was reported to a staff member at a specified meal time and was not immediately reported as per policy requirement.

Rationale and Summary
A day in August 2023, a staff member was informed by another staff, at a specified meal time of an abuse of a resident to another resident and did not immediately report the incident to the Administrator, Director of Care (DOC) or designate in charge of the home. The identified abuse incident information was given at the incoming staff during shift report that same day. A staff member from the incoming shift, immediately notified the DOC and the process for abuse was initiated as per policy.

In an interview, the first staff member indicated that they provided the information on the incident at the incoming shift report. The staff member indicated that they did not notify the DOC of the incident. In an interview, a second staff member indicated that they were made aware of the incident of abuse at the shift report and immediately notified the DOC and implemented the policy requirements.

By not complying with the home's abuse policy, there was potential risk for residents of reoccurrence of the behaviours.

Sources: record review, Zero Tolerance of Abuse and Neglect policy and interviews with staff members. [126]

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)

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Specifically, the licensee has failed to immediately notify the Director of an abuse incident that occurred a day in August 2023.

Rationale and Summary
As per progress notes, a resident was observed exhibiting a specified behaviours toward another resident. A staff member contacted the Director Of Care (DOC) to inform them of the incident.

In an interview, a staff member indicated that when they contacted the DOC, they were told there was no need to report the incident as there was already a Critical Incident System Report (CIS) for the same resident and that the CIS would be updated.
In an interview, the DOC confirmed that the Director was not immediately notified of the incident of abuse.

As such, the Director was not kept up to date of the incident of abuse that occurred in the home.

Sources: Progress notes and interviews with staff member and DOC. [126]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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 the implementation of any standard or protocol issued by the Director with respect to infection protection and control.

The Director issued the “Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes” in April 2022.
Additional Requirement 9.1 of the IPAC Standard requires the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
e) Use of controls, including:
i. Environmental controls, including but not limited to, location/placement of residents’ equipment, cleaning, making hand hygiene products available.

Specifically, the licensee failed to ensure that hand hygiene product was available at the Personal Protective Equipment (PPE) station prior to entering and exiting a Covid-19 Outbreak Unit.

A day in October 2023, an Inspector observed that there was no hand hygiene product available at the PPE station located in front of the door of the Covid-19 Outbreak Unit. A mobile hand hygiene dispenser was observed with a note indicating that it was broken. Twenty minutes later, at the same PPE station, when exiting the unit, the Inspector noted that when doffing, hand hygiene product was still not available and had to walk a few meters to have access to hand hygiene product.

Interview held with Infection Prevention And Control (IPAC) Lead who indicated that hand hygiene product should be available at the PPE Station as hand hygiene was required when donning and doffing.

By not doing hand hygiene when exiting the Covid-19 Outbreak Unit there was potential risk of contamination between units.

Sources: Inspector’s observations and interview with IPAC Lead. [126]

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 has failed to ensure that the appropriate police service was immediately notified of any sexual abuse of a resident that the licensee suspects may constitute a criminal offence.

Specifically, the police were not notified of the incident of abuse on a specified day.

Rationale and Summary
A day in August 2023, a resident exhibited inappropriate behaviours toward a co-resident.

Interview held with a staff member who indicated that they had notified the DOC of the specified abuse but they were told that there was already a Critical Incident System Report (CIS) sent two days ago and would be updated. The staff indicated that the Police were not notified.
Interview held with the DOC who indicated that the Police were not notified.

As such, the resident's abuse toward co-resident was not investigated by a police force.

Sources: Record review and interviews with staff members. [126]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that, drugs were stored in an area or a medication cart that was secured and locked.
Specifically a medication cart was observed to be left unlocked in the hallway.

Rationale and Summary
A day in October 2023, an Inspector observed a medication cart that was unattended and unlocked in the hallway. At that time, a staff member was observed to be in the dining room and to have their back turned to the medication cart and was administering medication to a resident. The staff member did not notice, that the Inspector was opening and closing the drawers of the unlocked medication cart.

Discussion held with the staff member who indicated that the medication cart should be locked when not unattended.

By having the medication cart unlocked and unattended, there was potential risk for residents to have access to medications.

Sources: Observation and interview with staff member. [126]

WRITTEN NOTIFICATION: Medication Administration

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (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.

Rationale and Summary
A resident's progress notes indicated that the resident displayed responsive behaviours during care. A day in August 2023, the physician ordered a specified medication to take one-hour prior to care. Three weeks later, the physician increased the dosage of medication and added a second medication one-hour prior to care.

Review of electronic medication administration record (eMAR) for two months in 2023, showed that the resident was administered the medication once. The eMAR did not show any other notes related to the administration of the identified medications on the resident's shower days.

The staff member stated that they attempted to administer the medication and they were not successful but had not been documenting their attempts.
The DOC indicated staff should have noted the outcome of the drug administration on the eMAR.

By not administering the medication as prescribed, the effectiveness of the interventions to address the resident's behaviours could not be evaluated.

Sources: Resident's health record (eMAR, progress note, plan of care, physician's order). Interview with staff members. [502]

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Develop and implement strategies to protect other residents from abuse by a resident.
- Audit once a week, for a period of four weeks, to determine if interventions implemented to protect other residents are effective.
- Document the effectiveness and any action taken if the interventions are ineffective.
- Review the Zero Tolerance of Abuse policy and the mandatory reporting requirements with direct care staff who work on the resident's unit and;
- Keep documentation that include the date the policy was reviewed, who provided the revision and all staff members who attended.

Grounds

The licensee has failed to ensure that other residents were protected from abuse by a resident.

Specifically, a resident was observed displaying inappropriate behaviours toward a co-resident two days after they had exhibited the same behaviours toward another resident.

Rationale and Summary

A day in August 2023, a resident was observed displaying an inappropriate responsive manner toward a co-resident. The incident was reported to a staff member at a specified mealtime and was reported at the incoming staff during shift report. The staff member did not comply with the home's Abuse policy by not immediately reporting.

Two days later, the resident was observed displaying the same inappropriate responsive behaviours toward another co-resident. That incident was not immediately reported to the Director and Police were not notified.

Furthermore, it was noted that within a two month period in 2023, the resident had displayed the inappropriate responsive behaviours toward three other co-residents.

As such, the resident's identified inappropriate behaviours were high risk for co-residents to be abused.

Sources:

Interviews with staff member and record review including Critical Incidents System Report and progress notes. [126]

This order must be complied with by December 4, 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.