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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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 24, 2024	
Inspection Number: 2024-1523-0003	
Inspection Type: Complaint Critical Incident	
Licensee: The Ottawa Jewish Home for the Aged	
Long Term Care Home and City: Hillel Lodge, Ottawa	
Lead Inspector Pamela Finnikin (720492)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-25, 29-30, 2024 and May 1-2, 2024.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake: #00106251/CI #3029-000001-24 related to disease outbreak

The following intakes were completed in this complaint inspection:

- Intake: #00109150 related to care concerns for a resident
- Intake: #00109801 related to safe and secure home with regards to a resident

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Dealing with complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to respond to written complaints made by a complainant on two occasions related to the care of a resident as required.

Rationale and Summary

#1

The LTCH received a letter of complaint that outlined concerns related to the care of a resident in April 2024.

The Director of Care stated that the complainant was responded to by email.

The response email was reviewed and failed to include an explanation of what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and 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 included concerns about care not being provided to the resident as per the resident's care plan.

The Director of Care confirmed that no further written correspondence or follow up was made to the complainant after the initial email response.

#2

The LTCH received an email of complaint that outlined concerns related to the care of a resident in April 2024.

The Director of Care stated that the complainant was responded to by an emailed letter the next day.

The response letter was reviewed and failed to include that the licensee would

immediately forward the complaint to the Director as required, as the letter included concerns about the resident receiving improper care by a staff member.

Sources: Complaint email and response letters and interview with the Director of Care.

[720492]