Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2019	2019_770178_0018	016155-19	Complaint

Licensee/Titulaire de permis

The Ottawa Jewish Home for the Aged
10 Nadolny Sachs Private OTTAWA ON K2A 4G7

Long-Term Care Home/Foyer de soins de longue durée

Hillel Lodge
10 Nadolny Sachs Private OTTAWA ON K2A 4G7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 5, 6, 2019.

Log #016155-19 regarding a resident to resident altercation was inspected.

During the course of the inspection, the inspector(s) spoke with a Personal Support Workers (PSW), Registered Practical Nurses, the Director or Nursing, a resident, and the family of a resident.

During the course of the inspection the inspector also observed residents and resident care and reviewed residents' medical health records.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #008 was based on an interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers.

Review of the medical health record indicated that Resident #008 is a competent resident who makes their own decisions and is not cognitive impaired.

The Director of Nursing (DON) indicated that resident #008 loses their temper quickly and has a history of verbal altercations with resident #009. The DON indicated that interventions have been put in place to prevent altercations between resident #008 and resident #009. The DON further indicated that on an identified date, resident #008 became involved in a verbal altercation with resident #007, and then hit resident #007 on the top of their head using the outer aspect of their hand with a closed fist. Critical Incident Report (CIR) # C601-000017-19 was submitted by the licensee, reporting the incident.

Inspector #178 reviewed the written plan of care for resident #008 on September 6, 2019. Resident #008's plan of care did not indicate a history or risk of verbal or physical altercations with other residents, and contained no interventions to prevent future altercations. The DON indicated that resident #008's written plan of care should have included the resident to resident physical altercation and measures to prevent future altercations.

As such, the plan of care for resident #008 was not based on an interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care for resident #008 is based on an interdisciplinary assessment of mood and behaviour patterns, including any identified responsive behaviours and any potential behavioural triggers, to be implemented voluntarily.

Issued on this 30th day of September, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.