Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 24, 2020 | 2020_665551_0010 | 004916-20, 006082-20, 006606-20, 009765-20, 010194-20, 013486-20 | 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

MEGAN MACPHAIL (551), PAULA MACDONALD (138)

## 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): July 8-10, 13-17 and 20-21, 2020.**

**The following logs were inspected:**
**004916-20 related to concerns about the care of a resident.**
**006082-20 related to concerns about the care of a resident.**
**006606-20 related to concerns about the care of a resident.**
**009765-20 related to concerns about the care of a resident.**
**010194-20 related to concerns about the method used to transfer a resident.**
**013486-20 related to concerns about the care of a resident.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Practical Nurses, the Assistant Director of Nursing, the Director of Nursing and the Chief Executive Officer.**

**During the course of the inspection, the inspector(s) viewed camera footage and photos and reviewed health care records.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Hospitalization and Change in Condition**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 35. Foot care and nail care**

**Specifically failed to comply with the following:**

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 received basic foot care services, including cutting of toenails.

On a specified date, photos were taken showing that resident #001's toe nails had not been cut.

According to two PSWs and one RPN who were interviewed, the home's staff did not cut the resident's toe nails as it was assumed that the resident's family member managed the resident's toenail care.

Log 009765-20 [s. 35. (1)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #002 while using a mechanical lift.

A video of a mechanical lift transfer of resident #002 by PSW #111 and RPN #103 on a specified date was reviewed. The video showed that the sling used for the transfer with the mechanical lift was not properly positioned under resident #002. This resulted in improper positioning of resident #002 and verbalization of pain by the resident at the start of the transfer and again when the transfer was paused then resumed by staff.

Discussion was held with RPN #103 about the transfer for resident #002 using the mechanical lift. The RPN stated that the sling used for the transfer was not initially positioned correctly under the resident for transfer with the mechanical lift.

As such, RPN #103 and PSW #111 did not use safe transferring and positioning techniques when assisting resident #002 while using a mechanical lift resulting in pain to the resident.

Log 010194-20 [s. 36.]

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**Issued on this 5th day of August, 2020**

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

**Original report signed by the inspector.**