Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2015	2015_198117_0001	O-000520-14	Critical Incident System

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

LYNE DUCHESNE (117), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 8, 9, 12, 13, 14 and 16, 2015

It is noted that twelve (12) critical incident inspections were conducted during this inspection. The logs are as follows: #O-000520-14, #O-000672-14, #O-000777-14, # O-001034-14, #O-001070-14, #O-001123-14, #O-001166-14, #O-001180-14, #O-001198 -14, #O-001265-14, #O-001268-14, and #O-001518-15

During the course of the inspection, the inspector(s) spoke with Chief Executive Director, Vice-President of Nursing Practice, Vice-President of Clinical Care, Clinical Care Coordinator, an attending physician, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSWs), Rehabilitation & Restorative Care Lead, Restorative Care staff members, a Physiotherapist, and to several residents. The inspectors also reviewed identified residents health care records, policies, and other documentation within the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written plan of care sets out the planned care for the resident. [Log #O-000777-14]

Resident # 8 was admitted to the home on a specific day in February 2014, from another long-term care home. The resident has advanced dementia, is an active wanderer with swallowing difficulties and pocketing of food. The resident is also known to try to occasionally take and eat other residents' food. This was clearly identified in the Registered Dietician's assessment of Resident #8's dietary needs as well as in the plan of care at the time of the resident's admission.

On a specific day in July 2014, Resident #8 was found lying on the bed of another resident with an earring on the floor beside the bed. The resident was coughing with excess mucus sputum when Resident #8 coughed up another earring. The resident was assessed by registered staff and changes in the resident's vital signs and breathing were noted. The attending physician and the resident's spouse were notified of the resident's ingestion of a foreign object and of Resident #8's change in condition. The resident was transferred and admitted to hospital.

A review of Resident #8's health care record was conducted. Transfer information from the previous LTC home and the Community Care Access Centre (CCAC) did not identify any behaviours or concerns with Resident #8 ingesting/pocketing of foreign objects. A review of progress notes showed that two days after Resident #8's admission to the home, the resident was putting paper clips in his/her mouth. Further documentation shows that the resident was putting a plastic cover of jam container (single small container use for bread at breakfast), earrings, and other small objects in his/her mouth.

On a specific day in April 2014, documentation indicates that during the resident's admission care conference, the attending physician and nursing staff spoke with Resident #8's spouse regarding the resident's ongoing wandering and pocketing of foreign objects in his/her mouth other than food. Eleven (11) days prior to the ingestion of the earrings, Resident #8 was found with one AA battery in his/her mouth. This was immediately removed by staff. A review of Resident #8's plan of care did identify that the resident was known for the pocketing of food and trying to take other resident's food. However, there was no identification that the resident was pocketing non-food items in his/her mouth.

On January 12 2015, staff members S#119 and S#120 told Inspector #117 that regular staff on the unit were aware that Resident #8 was an active wanderer who would like to take small objects and put these in his/her mouth. They state that they were aware of the need to monitor the resident, removed any foreign objects from the mouth and redirect the resident, this since almost the time of the resident's admission.

On January 14 2015, unit RPN S#121, PSW S#122 and BSO PSW S#123 confirmed that regular staff were aware of the resident's behaviours of putting foreign objects in his/her mouth and that the behaviour was noted a few days after the resident's admission to the home. The staff members all confirmed that part time and casual staff were made aware of the resident's behaviours and need for monitoring. Unit RPN S#121 confirmed upon review of plan of care that this behaviour was not identified in the plan of care until after incident of July 2014 in which Resident #8 swallowed an earring which led to his/her transfer and admission to hospital.

Resident #8's written plan of care did not set out the planned care for the resident in regards to behaviours of ingesting and pocketing of foreign objects in his/her mouth. [s. 6. (1) (a)]

2. The licensee has failed to comply with LTCHA, 2007 S.O.2007, c.8, s.6 (7) in that the licensee specifically failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [Log #O-000672-14]

Resident # 001's Critical Incident Report (CIS) as well as skin and wound progress notes in the resident's health care record, dated on a specific day in June 2014, indicate that Resident #001 sustained an approximately 4 cm long laceration to a lower leg when two PSW staff members tried to transfer Resident #001 from bed to wheel chair.

Resident #001's plan of care in place at the time of incident was reviewed by Inspector #573. The plan indicates "TRANSFER: Resident requires a mechanical lift for all transfers". Further review of the daily care record report, which includes information regarding Resident #001's transfers, was conducted. For nine (9) days in May and nine (9) days in June 2014, information recorded by PSW staff members indicates that Resident #001 was transferred between bed to chair by 2 staff members with staff providing weight bearing assistance, with no indication that a mechanical lift was used for transfers as was identified in the plan of care.

On January 9 2015, Inspector #573 interviewed RPN S#104 and PSW S#106. Both staff members stated that Resident #001 was transferred by 2 staff members using side by side assistance until a specific day in June 2014, 15 days after the noted incident of an injury, when Resident #001 was transferred to hospital.

During an interview on January 9 2015, with PSW S#102 who provides direct care to Resident #001, the PSW stated that at this time the resident is transferred by 2 staff members using side by side transfer for toileting and that a mechanical lift is used only to transfer resident #001 from bed to wheel chair. It is noted that Resident #001's current plan of care, which is in effect since a specific day in November 2014, identifies that Resident #001 requires a mechanical lift for all transfers.

Resident #001's care set out in the plan of care regarding transfers was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to comply with LTCHA, 2007 S.O.2007, c.8, s.6 (7) in that the licensee specifically failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [Log #O-001180-14]

Resident # 003's health care identifies that the resident is at high risk for falls and has history of multiple falls.

Resident #003's current plan of care was reviewed by Inspector #573. The plan indicates that Resident #003 is at High risk of falls due to self-transfer. Fall prevention interventions identified in the plan include, the use of a bed/chair alarm, anti-slip surface for wheelchair seat cushion, use of raised toilet seat for toileting, appropriate footwear and hourly safety checks. Nursing rehabilitation progress note documentation indicate that on a specific day in October 2014 that a bed/chair alarm has been assigned to the resident due latest falls and the care plan was updated and staff informed of this new intervention.

On January 12 and 13 2015, Inspector #573 observed Resident # 003 sitting in a wheel chair without any chair alarm attached to the Resident.

On January 13 2015, Inspector # 573 interviewed PSW S#113 about Resident #003 in relation to a bed/wheelchair alarm. PSW S#113 stated that when Nursing Rehabilitation staff member initially applied the bed/chair alarm, this alarm was regularly used. However, the PSW indicated that currently staff don't use or apply the bed/chair alarm for Resident# 003.

On January 13 2015, the RPN S#112 stated that PSW staff members are supposed to apply the bed/chair alarm for Resident #003. The RPN further confirmed with Inspector #573 that the PSW staff members did not apply the chair alarm to the Resident #003 while the resident is sitting in the wheel chair.

Resident #003's care set out in the plan of care regarding falls prevention was not provided to the resident as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident‘s care needs change or care set out in the plan is no longer necessary. [Log #O-00107-14]

Resident #002 is identified as being at high risk of falls. As per a critical incident report, on a specific day in September 2014, Resident #002 had an unwitnessed fall resulting in a fracture. Resident #002's current written plan of care for falls prevention was reviewed

by Inspector #573. The current plan of care, as well as the previous plan of care dated July 2014, notes under Therapy services, that the resident is receiving the following interventions: "Active Range of motion both upper and lower extremities – Balance and weight bearing exercise at the rail". Resident #002's Physiotherapist quarterly assessments dated July 2014, and January 2015, indicate that Resident #002 is not on physiotherapy program due to refusal of services however, the plan of care still indicates that the resident is receiving physiotherapy services for balance and weight bearing exercises.

On January 12 2015, the Physiotherapist confirmed to Inspector # 573 that Resident #002 is not receiving any therapy services or interventions at this time. The Physiotherapist also indicated that Resident #002's written plan of care was reviewed but was not revised after the resident refused post fracture physiotherapy services.

The licensee has failed to ensure that Resident #002's written plan of care regarding physiotherapy interventions is revised when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

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 1) the written plan of care for Resident #8 sets out the planned care in regards to responsive behaviours of ingestion and pocketing of foreign objects, 2) the care set out in the plan of care is provided to the Resident #001 as it relates to the use of mechanical lifts for transfers and to Resident #003 as it relates to the use and application of bed/chair alarms, and 3)to ensure that when Resident #002 is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary especially as it relates to the physiotherapy services, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, is reviewed and, if required, revised. O. Reg. 79/10, s. 29. [Log #O-001123-14]

Resident # 005's Critical Incident Report and fall incident note in the resident's health care record, dated for a specific day in October 2014, indicate that Resident #005 had a unwitnessed fall from wheelchair which resulted in laceration to occipital area while resident was on trial for wheel chair seat belt restraint removal and later resident was sent to hospital for further treatment.

A review of the resident's health care record and fall prevention interventions was conducted by Inspector #573. Communication between the home and Resident #005's Substitute Decision Maker (SDM) was reviewed. Documentation shows that on a specific day in October 2014, three (3) days after the resident's fall and injury, Resident #005's SDM emailed to the Home's Social worker stating that she was concerned and not aware that Resident #005 was participating in the trial for wheel chair seat belt restraint removal. Furthermore, the SDM indicated in the email that she does not think it was a good idea to have the resident using her wheelchair without a seat belt restraint.

Documentation shows that on the same day, the Home's Rehabilitation and Restorative lead responded to the Resident #005's SDM through an email indicating that she apologized for the staff who initiated the wheel chair seat belt restraint removal program for Resident #005 without going through the proper procedures for this program.

On January 14 2015, Inspector #573 reviewed information and procedures related to the wheelchair seat belt restraint removal program with the unit RPN S#114 and the Rehabilitation and Restorative Care Lead. Documentation showed that in September 2014, Resident #005 was identified as a potential candidate for the program, but that the resident's SDM had not yet been consulted and not yet consented regarding Resident #005's participation in the program. This information was confirmed by the Rehabilitation and Restorative Care Lead.

On January 14 2015, Inspector # 573 spoke with Resident #005's SDM who confirmed that the Home did not contact her for consent regarding the trial wheel chair seat belt restraint removal for Resident #005. [s. 29.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure, whereby the Director was not informed immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. [Log#O-001518-15]

On January 8 2015, Inspectors #117 and #573 arrived at the long-term care home to conduct unannounced inspections. At the home's front entrance was a notice to all visitors that the home had respiratory outbreaks on two resident care units. The Inspectors had reviewed notices to the Director prior to their arrival to the home and no information had been received from home related to a respiratory outbreak.

On January 8, 2015 the Vice President of Nursing Programs was interviewed by Inspector #573, who indicated that the home had been declared in respiratory outbreak by the Public Health Unit on December 24, 2014. The Vice President of Nursing Programs confirmed that the home had not notified the Director of the respiratory outbreak. She stated that the reason for not reporting the outbreak was the assumption given by the public health inspector that the local public health unit would be reporting this to the Director.

The Director was informed of the Respiratory Outbreak in the home via the Critical Incident System Report submitted on January 09, 2015. [s. 107. (1) 5.]

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Issued on this 20th day of January, 2015

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

Original report signed by the inspector.