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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2016	2016_330573_0016	0011079-16, 012606, 011244, 011972, 015032, 015020, 013950, 016954, 020370, 018589, 013924-16	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

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): July 04, 05, 06, 07, 08, 11, 12, 13, 14, 15, 18 and 19, 2016.

The following critical incident logs were inspected:
Log# 0011079-16, 013950-16 and 011972-16 related to an incident that causes an injury to a resident for which resident was transferred to hospital.
Log# 012606-16, 011244-16, 015032-16 and 015020-16 related to fall that causes an injury to a resident and resulted in a significant change in condition.
Log# 020370-16 and 018589-16 related to a resident to resident alleged sexual abuse.
Log# 016954-16 related to a resident to resident alleged physical abuse.
Log# 013924-16 related to a staff to resident alleged emotional abuse/neglect.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Support Ontario (BSO) champion staff, Physiotherapist Assistant (PTA), Registered Physiotherapist, Human Resources and Staff Development Manager, Vice President (VP) of Clinical Care, Vice President (VP) of Nursing Programs and the President and Chief Executive Officer (CEO).

The inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, PSW flow sheets, BSO work sheets and Geriatric Psychiatry Outreach reports/progress notes), home's internal investigation report and the home's written policy to promote zero tolerance of abuse and neglect of residents. Inspector reviewed Home's program for Responsive Behaviours. In addition, the inspector also observed resident care and resident rooms.

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.

4 WN(s)
3 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #014's plan of care set out clear direction to staff and others who provide direct care to the resident, specifically related to the interventions to manage resident #014's sexual behaviours.

A critical incident report (CIR) was submitted to the Director for a resident #014 to resident #015 alleged sexual abuse incident that occurred on a specified date. After 22 days a second CIR was submitted to the Director for a resident #014 to resident #016 alleged sexual abuse incident that occurred on a specified date.

On July 14, 2016, Inspector #573 reviewed resident #014's care plan at the time of both the incidents and the current care plan in place for resident's responsive behaviours. Resident #014's care plan identifies that resident exhibits inappropriate sexual behaviours - inviting residents to bed room. Upon review, inspector found that resident #014's care plan does not have any specific interventions for staff regarding how to manage resident's sexual behaviours, including the need for heightened monitoring when resident #014 displayed any inappropriate sexual behaviours towards other residents in the unit.

On July 15, 2016, Inspector #573 discussed the care plan in place for resident #014 in the presence of Vice President of Nursing Programs. After review, the V. P Nursing Programs indicated to Inspector #573 that resident #014's care plan does not provide

clear direction for staff regarding specific intervention on how to manage resident #014 sexual behaviours. Further she indicated that the written plan of care does not direct staff on how to monitor /manage when resident #014 exhibits sexual behaviours towards other residents in the unit.(Log #020370-16) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care in relation to the use of wheelchair seat belt and table top (PASD) was used for resident #004 as specified in the plan.

Critical Incident Report (CIR) indicated that on a specified date, resident #004 was found in face-down body position on the floor in front of the resident's washroom. Further the CIR report indicated that resident #004 was sent to hospital for further assessment and returned to the home without any injuries.

Inspector #573 reviewed resident #004's care plan at the time of incident, which identifies that the resident #004 is at risk for fall due to sliding from the wheelchair. Further resident #004 plan of care directs staff to always use wheel chair seat belt and table top as a personal assistance services device (PASD) when resident is sitting in the wheelchair.

A review of resident #004's progress notes for the fall incident on a specified date, indicated that at the time of fall, resident #004 was left unattended by the PSW staff members in the resident bedroom without applying the wheel chair seat belt and table top to the resident.

During an interview on July 06, 2016, with Manager of Human Resources and the Vice President of Nursing Programs both confirmed to inspector that on a specified date, while resident #004 was sitting in the wheel chair, the PSW staff members did not apply the wheel chair table top and failed to ensure that the wheel chair seat belt was applied for resident #004's safety as per the care plan.

Resident #004's care set out in the plan of care regarding the use of wheel chair seat belt and table top as PASD to prevent resident from falls was not provided to the resident as specified in the plan.(Log #012606-16) [s. 6. (7)]

3. A Critical Incident Report (CIS) indicated that on a specified date, resident #010 was found on the floor in resident's washroom. Further the CIS report indicated that resident #010 was sent to the hospital for further assessment and was diagnosed with a specific injury which resulted in significant change in condition.

Inspector #573 reviewed resident #010's care plan at the time of incident, which identifies that the resident #010 is at high risk for falls related to resident's unawareness towards safety needs. The plan of care identifies the use of physical restraint in wheelchair for prevention of falls. Further resident #010 written plan of care for toilet use indicates that resident requires extensive assistance with one staff.

On July 08, 2016, Inspector #573 spoke with RPN #100 who indicated that on a specified date, she transferred resident #010 from wheelchair to the toilet seat by herself and left the resident unattended on the toilet to get a towel. Further the RPN #100 indicated to inspector that she is aware that resident is at high risk for falls when left unattended in the toilet.

Resident #010's care set out in the plan of care regarding falls/ safety needs was not provided to the resident as specified in the plan, which resulted in an injury to the resident.(Log #015032-16) [s. 6. (7)]

4. A review of after hours incident report to MOHLTC indicated that on a specified date, when resident #006 requested PSW #105 for repositioning in the bed, the PSW #105 informed resident #006 that she could not reposition the resident since she did not have anyone to help her and never came back to reposition the resident #006.

Inspector #573 reviewed resident #006's quarterly assessment at the time of incident which identifies that the resident #006 had stageable pressure ulcers and the skin treatment included the repositioning program. Further resident's bed mobility assessment identifies that resident #006 requires extensive assistance with two people. Inspector #573 reviewed resident #006's care plan at the time of incident which indicates "staff to turn, reposition resident at least every two hours, more often as needed or requested"

Inspector #573 spoke with PSW #105, who indicated that on a specified date, when resident #006 requested for repositioning in the bed, PSW #105 did not reposition the resident with her co-worker nor did she report to the other staff during the shift regarding resident #006's request for repositioning in the bed.

On July 08, 2016, Inspector #573 spoke with the home's Manager for Human Resources who indicated that the home started an immediate investigation related to the incident. The Manager stated to inspector that the PSW #105 was immediately placed on an administrative leave and has not returned back to work since the incident. Further she

reported that the home is still in the process of completing the internal investigation.

The plan of care regarding resident #006's repositioning in the bed was not provided to the resident as specified in the plan.(Log #013924-16) [s. 6. (7)]

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 a) resident #014's plan of care set out clear direction to staff and others who provide direct care to the resident, specifically related to the interventions to manage resident #014's sexual behaviours. b) to ensure that the care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy "Falls Prevention and Management" was complied with.

According to O.Reg. 79/10, s. 48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls preventions and management program to reduce the incident of falls and the

risk of injury.

Review of the homes policy "Fall Prevention and Management" (IX NSG E-11.00) under Falls Risk Factors and Related Interventions : For urinary frequency and symptoms like rushing to bathroom or unsafe maneuvering /toileting, it indicates to implement a program to promote resident's continence.

Resident # 011's Critical Incident Report (CIR) indicated that on a specified date, resident self-reported to registered nursing staff that resident had a fall. Further the CIR report indicated that resident #011 was sent to the hospital for further assessment and diagnosed with a specific injury which resulted in significant change in condition.

On July 08, 2016, Inspector #573 reviewed resident #011's health care record (post fall assessment) for three (3) specific months prior to the fall incident on a specified date. Upon review, it was found that resident #011 sustained five (5) falls which were all related to resident toileting needs.

- on a specified date and time, resident found on floor next to the bed, resident indicated that she/he went to the bathroom and fell down.
- on a specified date and time, resident reported that she/he had a fall and sustained skin tears. At the time of post fall assessment, resident was incontinent of bladder and urine was found in the floor next to the bed.
- on a specified date and time, resident found on puddle of urine in the floor next to the bed. Resident indicated that she/he needed to use the bathroom.
- on a specified date and time, resident got out of the bed to use the bathroom. While walking to the bathroom, she/he lost balance and had a fall with injury to head.
- on a specified date and time, resident had a fall in the bed room. Upon post fall assessment, resident indicated that she/he needed to go to the bathroom.

Review of the care plan (for three (3) specific months) for resident #011 indicated that the resident was at "high risk" for falls and fall prevention interventions were in place in the care plan. There was no indication in the care plan regarding a specific toileting schedule /program that was implemented for resident #011 to promote continence and no other approaches were considered when the resident continued to fall related to toileting. There was no indication in the care plan that the resident was placed in the program to promote resident's continence as per the home's policy.

On July 08, 2016, Inspector #573 reviewed resident #011's post fall assessments and

progress notes related to falls in the presence of Vice president of Nursing Programs. Upon review, the V.P Nursing Programs indicated to inspector that resident #011's falls on the above identified dates were related to toileting needs. Further she indicated that resident should have been on the home's toileting program to promote resident #011's continence as per the home's policy.(Log #015020 -16) [s. 8. (1) (a),s. 8. (1) (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 the home's policy "Falls Prevention and Management" was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviours: specifically
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring.

Inspector #573 reviewed home's nursing policy manual for required programs subject: Responsive Behaviours revision date July 2016. Upon review, Inspector #573 observed that home's program for Responsive Behaviours does not have the written information in

accordance with O. Reg. 79/10,s. 53. (1)

On July 19, 2016, during an interview with Vice President of Nursing Programs and Vice President of Clinical Care, both indicated to Inspector #573 that the home's responsive behaviours program does not contain written approaches to care, including the type of screening protocols, assessments and reassessments used to identify the behavioural triggers that may result in responsive behaviours. Further the program does not have written strategies including the specific techniques and interventions followed by the staff to prevent minimize or respond to the responsive behaviours. Review of the home's responsive behaviours program does not include resident monitoring for responsive behaviours.(Log #018589-16) [s. 53. (1)]

2. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident #014 sexual responsive behaviours (where possible) and actions are taken to respond to the needs of the resident #014, including assessments, reassessments and interventions and that the resident's response to interventions are documented.

A critical incident report (CIR) was submitted to the Director for a resident #014 to resident #015 alleged sexual abuse incident that occurred on a specified date.

Resident #014 was admitted in the home with responsive behaviour and was receiving anti-psychotic and antidepressant medications to manage behaviours. Resident #014 progress notes indicates that resident had history of exhibiting sexual behaviours towards other resident in the unit.

A review of resident #015's assessment at the time of incident indicates that resident is severely impaired for cognitive skills for daily decision making.

Inspector spoke with PSW #101, who indicated that on a specified date, during her shift in the evening, she observed resident #014 saying inappropriate sexual comments and giving sexual invitation towards resident #015. PSW #101 indicated that she immediately separated both the residents and re -directed resident #014 to her/his room. Further PSW #101 indicated that she did not report resident #014's sexual behaviours towards resident #015 to the RPN. During an interview with RPN #102, who indicated that on the same specified date at night time, when she could not find resident #015 in the hallway to administer medications she started searching for resident #015 in other resident rooms. Further the RPN #102 indicated that upon searching in resident #014's bedroom, she

witnessed resident #014 physically on top of resident #015 with genitals exposed.

Inspector spoke with RN #104 who indicated that after the incident on a specified date, resident #014 was seen by BSO, psycho geriatric team and behaviour mapping was initiated to monitor resident #014's sexual behaviour.

After 22 days a second CIR was submitted to the Director for a resident #014 to resident #016 alleged sexual abuse incident that occurred on a specified date.

On July 14, 2016, Inspector spoke with RPN #103, who indicated that resident #014 was transferred from unit (A) to another unit (B) on a specified date. At the time of resident #014's transfer of care, she was informed about resident sexual abuse incident that occurred on a specified date. Further the RPN #103 indicated to inspector that the information related to resident's sexual behaviours and the interventions specifically on how to manage resident #014's sexual behaviour were not communicated or discussed at the time of resident #014's transfer to the unit (B).

During an interview RPN #103 indicated to inspector that on a specified date, at dinner time she observed resident #014 saying sexually inappropriate comments and giving sexual invitation towards co resident #017 who was sitting in the dining room. The RPN #103 indicated that she immediately informed PSW staff in unit to monitor both the residents. On the same day at night hours, RPN #103 observed resident #014 was sitting next to resident #017 near the nursing station and RPN #103 requested resident #014 to go to the bedroom. When resident #014 walked by RPN, resident #014 whispered in resident #017 ears "I am going to bed now. Meet me in my room ". RPN #103 indicated to the inspector that she immediately informed the PSW in the unit to keep a close eye on resident #017. Further the RPN #103 indicated that approximately after 10 Minutes, when she enquired about resident #014, PSW staff indicated that resident #014 was wandering in the hallway. RPN #103 went to observe resident #014, who was not seen in the hallway or in the resident room. Upon searching for the resident #014, RPN # 103 heard resident #016 calling from the bedroom "please help" and the RPN witnessed resident #014 was leaning forward towards and touching resident #016 inappropriately in resident #016's bedroom. RPN #103 immediately removed resident #014 from that area. After the incident RPN #103 indicated to inspector that a behaviour mapping and one on one observation was initiated for resident #014. Inspector #573 observed that resident #014's one on one observation by staff was in place at the time of inspection.

Inspector #573 spoke with home's BSO Staff #106, who indicated that resident #014's

responsive behaviours including resident's sexual behaviours were discussed with the unit (B) staff members. Further she indicated that strategies and interventions for staff to manage resident #014's sexual behaviours are documented and kept in unit (BSO Responsive Behaviours) binder on the floor.

On July 14, 2016, Inspector #573 reviewed resident #014's health care records in the presence of RN #104. Upon review, inspector found that there was no behaviour mapping initiated after the first incident on a specified date and the behaviour mapping tool initiated after the second incident does not capture resident #014's verbal or physical sexual behaviours. A review of BSO worksheet binder in the unit does not have any information or any interventions for staff to manage resident #014's sexual behaviours. Further resident #014 care plan for responsive behaviours does not provide strategies for staff, specifically on how to monitor resident #014 while resident exhibiting sexual behaviours towards other residents in the unit.

On July 15, 2016, during an interview with Vice President of Nursing Programs, who indicated after the first incident on a specified date, registered nursing staff was instructed to initiate behaviour mapping to monitor resident's sexual behaviour. Further after a review of resident #014's care plan and BSO work sheet for resident #014, the V.P Nursing Programs indicated to inspector that resident #014's care plan for responsive behaviours does not provide clear strategies and interventions for staff specifically to manage resident #014 sexual behaviours. Further the V.P Nursing Programs indicated that the resident #014's care plan does not identify the need for heightened monitoring for resident #014 since resident #014's sexual behaviour pose a potential risk to other residents in the unit.(Log #018589-16) [s. 53. (4)]

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 (a) to ensure the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring.
(b) to ensure that strategies were developed and implemented to respond to the resident #014 sexual responsive behaviours (where possible) and actions are taken to respond to the needs of the resident #014, including assessments, reassessments and interventions and that the resident's response to interventions are documented., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that under s. 23 (2), to provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

According LTCHA S. 23 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

On March 28, 2012, a memorandum related to reporting investigation Under LTCHA S. 23(2) and Time frame of Final Report Under O.Reg. 79/10 S.104 (3) was sent to all Long -Term Care Homes from Ministry of Health and Long Term Care. In that memo, it was indicated "referenced in section 104(3) of the Regulation is twenty-one (21) days, unless otherwise specified by the Director".

A report was made to the Ministry of Health and Long Term Care on a specified date, related to alleged Improper/Incompetent treatment of a resident that results in harm or risk to a resident.

On July 08, 2016, Inspector #573 spoke with the Manager of Human Resources who indicated that the home started an immediate investigation related to the incident. Further the Manager stated to inspector that the home is still in the process of conducting internal investigation and the investigations were not yet completed.

On July 09, 2016, during an interview with home's Vice President of Clinical Care, who indicated to Inspector #573 that the home has failed to submit the final report to the Director within the specified (twenty-one (21) days) time frame.(Log #013924-16) [s. 104. (3)]

Issued on this 22nd day of July, 2016

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

Original report signed by the inspector.