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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 9, 2016	2016_417178_0009	008819-16, 009665-16, 010142-16, 011560-16	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

SUSAN LUI (178)

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 12, 13, 14, 2016 onsite. July 18, 20, 2016 offsite.

During the course of the inspection, the inspector(s) spoke with the Manager of Human Resources and Staff Development, Vice President-Clinical Care, Vice President-Nursing Programs, Coordinator of Quality Improvement, registered nurses, registered practical nurses, personal support workers, residents, a family member of a resident.

During the course of the inspection the inspector also observed residents and resident care, reviewed resident records, home training records, home Continuous Quality Improvement (CQI) records, and abuse investigation records.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

This finding is related to Log #008819-16.

Interviews with the home's Manager of Human Resources (HR) and Staff Development revealed that PSW #103 did not receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents. The Manager of HR and Staff Development confirmed that PSW #103 last received training in the home's policy to prevent abuse and neglect of residents in December 2013, during the orientation when all staff was moving into the newly built home.

Review of the home's training records confirmed that PSW #103 received General Orientation in December 2013.

PSW #103 was overheard yelling at a resident by the resident's family members on an identified date in 2016, and as a result received discipline from the home.

During an interview, PSW #103 confirmed that he/she had once received training in the prevention of abuse and neglect of residents, but was unsure of how many years it has been since this training took place. [s. 76. (4)]

2. This finding is related to Log #010142-16.

Interviews with the home's Manager of HR and Staff Development revealed that RPN #106 did not receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents. The Manager of HR and Staff Development confirmed that RPN #106 last received training in the home's policy to prevent abuse and neglect of residents in May 2013.

RPN #106 was witnessed yelling at a resident on an identified date in 2016, and as a result received discipline from the home.

During an interview, RPN #106 confirmed that he/she had received training in the home's policy to prevent abuse and neglect of residents in the past, but not since the home moved to the new building. RPN #106 stated that he/she did not receive any abuse prevention training from late 2014 until present.

Review of the home's investigation file regarding the 2016 incident revealed that RPN #106 signed a Declaration of Acknowledgement and Understanding after receiving

discipline for the incident, declaring that he/she read and understood the policies, Standards of Employee Conduct, and Resident Abuse: Prevention, Reporting and Elimination. [s. 76. (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 to ensure that all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

This finding is related to Log #008819-16.

Review of an identified Critical Incident Report (CIR) revealed that on an identified date, the family of resident #001 reported to the nurse in charge that they overheard a personal support worker (PSW) yelling at the resident. According to the CIR, the nurse in charge provided the family with a "Speak Your Mind" form, which the family filled out. The form was received by the Vice President (VP) of Clinical Care two days later, at which time the Director under the Long-Term Care Homes Act (LTCHA) was informed via the after-hours number, and the home initiated an investigation into the allegations.

Interviews with the home's Manager of Human Resources and Staff Development confirmed the above sequence of events.

During an interview with the resident's family member, he/she was unsure as to whether or not the home had informed the family of the results of the home's investigation into the incident.

During interviews with the home's VP-Clinical Care, she could not recall whether or not resident #001's family had been informed of the results of the investigation, and stated that they do not always inform the families of the results of an investigation into an abuse allegation. [s. 97. (2)]

2. This finding is related to Log #009665-16.

Review of an identified Critical Incident Report (CIR) revealed that on an identified date, an identified RN working at the home reported to the home's VP of Clinical Care that he/she witnessed a PSW grab resident #002 by an identified body area in order to reposition the resident back into bed. According to the CIR, the MOH was informed of the allegation, and the PSW was put on administrative leave while the home investigated the incident.

Interviews with the home's Manager of Human Resources and Staff Development confirmed the above sequence of events and that the incident was investigated by herself in collaboration with the home's VP-Clinical Care.

During interviews, the home's VP-Clinical Care stated that she initiated the investigation along with the Manager of HR and Staff Development, but the investigation was completed by the VP-Nursing Programs. The VP-Clinical Care and the VP-Nursing Programs both confirmed that they did not inform the family of resident #002 of the results of the investigation. [s. 97. (2)]

3. This finding is related to Log #010142-16.

Review of an identified Critical Incident Report (CIR) revealed that a registered nurse (RN) witnessed an registered practical nurse (RPN) yell at resident #003. According to the CIR, the RPN was removed from the home, the MOH was informed, and the home conducted an investigation into the incident.

Interviews with the home's Manager of HR and Staff Development confirmed the above sequence of events and stated that the incident was investigated by herself in collaboration with the VP-Nursing Programs and the VP-Clinical Care.
Interview with the VP-Clinical Care stated that the incident was investigated by the VP-Nursing Programs and the Manager of HR and Staff Development.

Interview with the VP-Nursing Programs confirmed that she investigated the incident in collaboration with the Manager of HR, and that resident #003's family was not informed of the results of the investigation. The VP-Nursing Programs also stated that she does not always inform families of the results of an investigation into alleged abuse, especially when it is a staff complaint coming forward. She stated that families are always informed of the allegation, but not necessarily of the results of the investigation. [s. 97. (2)]

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 resident and resident's SDM are notified of the results of the alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

This finding is related to Log #008819-16.

Review of an identified Critical Incident Report (CIR) revealed that on an identified date, the family of resident #001 reported to the nurse in charge that they had overheard a personal support worker (PSW) yelling at the resident. According to the CIR, the nurse in charge provided the family with a "Speak Your Mind" form, which the family filled out. The form was received by the Vice President-Clinical Care two days later, at which time the Director under the Long-Term Care Homes Act (LTCHA) was informed via the after hours pager number. A CIR was submitted by the home the following day, which was three days after the incident took place.

Interviews with the home's Manager of Human Resources and Staff Development, and with RN #104 confirmed the above sequence of events.

An interview with RN #104 confirmed that he/she was told by resident #001's family that they had overheard the resident being yelled at by a staff member, and although the RN confirmed that this would be considered verbal abuse, the RN did not immediately report the allegation to the Director under the LTCHA. RN #104 confirmed that he/she should have informed the Ministry of Health immediately, and that all the nurses have since received re-education regarding immediate reporting of any suspicion of abuse of residents to the Ministry of Health via the CIR system or the after hours pager.

The same non-compliance was issued to the home during the 2016 Resident Quality Inspection #2016_290551_0006, and can be found on that report dated April 22, 2016. A VPC was issued at that time. Staff interviews and record review during the present inspection revealed that the home has taken actions to correct the non-compliance. [s. 24. (1)]

Issued on this 22nd day of August, 2016

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

Original report signed by the inspector.