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 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
Mar 9, 2017	2017_523461_0001	000666-17	Resident Quality Inspection

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

CRISTINA MONTOYA (461), AMANDA NIXON (148), CHRIS LAIDLAW (668), JENNIFER BATTEN (672), JOELLE TAILLEFER (211), SHIHANA RUMZI (604)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 23-27, 31, February 1-3, 2017

During the course of the inspection, the inspector(s) spoke with President and Chief Executive Officer (CEO), Vice President of Nursing (VPN), Assistant Vice President of Nursing (AVPN), Administrative Secretary, Manager of Support Services, Food Service Supervisor, Vice President of Building Operations, Recreation Lead Hand, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides; Houskeeping Staff, Recreologists, Rehabilitation and Restorative Service Lead, Volunteer Meal Assistant, Family Council Co-Chair person, Residents, Resident's Council Co-Chairs, Resident's Family Members.

During the course of the inspection, the inspector(s) also observed residents, reviewed health records of residents, reviewed maintenance records, reviewed the Home's menus, and the following policies: Nursing Policy Manual related to hand hygiene and narcotics administration; Pharmacy Services related to narcotic prescriptions and narcotic count inventory; Reviewed Narcotic Control Sheets, reviewed the Resident's Council Meeting Minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Recreation and Social Activities
Residents' Council

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, related to restraints/PASDs.

On specified dates, Inspectors #668, #672, and #461 observed residents #006, #007, #009 with restraints/PASDs in use.

Interviews with staff indicated that restraints/PASDs were used for the above identified residents.

It was determined that resident #006, #007 and #009 did not have a written plan of care which set out the planned care related to the use of restraints/PASDs.

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 ensuring that there is a written plan of care for each resident that sets out, the planned care for the residents related to bed rails, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On specified dates, Inspector #688 observed that resident #010's bathroom was dirty. The Inspector confirmed with staff members that the home's expectation was that the resident's bathrooms were to be cleaned daily.

On specified dates, Inspector #688 observed that resident #007's mobility device was soiled. The inspector confirmed with staff that the equipment needed to be cleaned.

Therefore, the home failed to ensure that furnishing and equipment were kept clean and sanitary.

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 ensuring that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Communication of the seven-day and daily menus to residents.

On a specified date, Inspector #461 observed that the snack menu was not communicated to the residents. The Inspector confirmed with staff that although the snack menus were available to staff, the daily and weekly snack menus were not communicated to residents.

Therefore, it was determined that the daily and weekly snack menus were not communicated to the residents.

2. The licensee has failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by resident.

On a specified date, Inspector #461 observed that resident #013 waited over 45 minutes for assistance with eating and drinking during a meal service, with the meal served sitting on the table.

Inspector #461 confirmed with staff members that resident #013 required assistance with the meal, and did not receive it.

On a specified date, Inspector #688 observed that residents #019, #020, and #021 were served meals during a meal service, and did not receive the required level of assistance.

Inspector #688 confirmed with staff that the above mentioned residents required assistance with meals.

Therefore, it was determined that residents #019, #020, and #021 who required feeding assistance, were served their meals before someone was available to provide the assistance required by the residents.

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 ensuring that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program, specifically related to hand hygiene.

On specified dates, Inspectors #668 and #461 observed during meal services that PSWs did not complete hand hygiene between clearing dirty dishes and serving meals to residents. Inspector #672 also observed staff conducting the nourishment pass did not conduct hand hygiene between assisting residents.

On specified dates, Inspector #672 observed that RPNs #127, #140, #142, and #152 did not complete hand hygiene when conducting medication administration between residents.

On specified dates, Inspector #672 observed an unlabelled bedpan sitting on top of the resident #009's shared bathroom counter.

In an interview with the home's Vice President of Nursing (VPN), Inspector #672 identified that the home's expectation was that staff perform hand hygiene when going from dirty to clean, between residents during medication administration, and also when providing assistance between residents during nourishment pass. The VPN also indicated that a bedpan should not have been left on a counter top, as it was not proper infection control practices.

Therefore, it was determined that several members of staff did not participate in the implementation of the infection prevention and control program, specifically related to hand hygiene.

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 ensuring that all staff participate in the implementation of the program, specifically related to hand hygiene, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

On specified dates, Inspector #668 and #461 observed during a identified meal services that planned pureed items were not available to residents. Inspector #668 and #461 confirmed with staff, the absence of the pureed meal options.

Therefore, it was determined that the planned menu items were not offered and available at each meal on identified meal services.

2. The licensee has failed to ensure that the evening meals are not served before 5:00 p.m.

On specified dates, Inspector #668 observed during the evening meal service that meals were served before 5:00 p.m.

Inspector # 668 interviewed the Manager of Support Services who indicated that the supper meal service was to start at 1630 hours.

Therefore, it was determined that the Home's evening meal was being served prior to 1700 hours.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During a specified three day period, Inspector #211 was unable to find the ACTIONline information, which was required to be posted in a conspicuous and easily accessible location.

On a specified date, Inspector #211 and Inspector #604 were able to locate the information, but it was not posted in a conspicuous and easily accessible location in a manner which complied with the legislative requirements. Additionally, the phone numbers with which to contact the Director were not posted accurately, when the information was finally located.

Inspector #211 interviewed multiple residents and staff members in the home, and none of these individuals were aware of the complaint procedure and how to contact the Director, or where to find the information in the home.

Therefore, it was determined that the licensee failed to ensure that the required information was posted in the home, in a conspicuous and an easily accessible location, in a manner that complied with the requirements.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On a specified date, Inspector #672 observed a narcotic medication was being stored outside of the separate, locked area within the locked medication cart.

Inspector #672 verified with a Registered Staff member that the narcotic was being stored outside of the required locked area within the medication cart. The VPN also confirmed that the home's expectation was that all narcotics were to be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Therefore, the licensee failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Issued on this 10th day of March, 2017

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

Original report signed by the inspector.