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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2019	2019_618211_0018	012169-19, 013989-19	Complaint

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive 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

JOELLE TAILLEFER (211)

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 22, 23, 24, 25, 30, 2019.

The following logs were inspected:
-Intake #012169-19 related to Personal Support Services and Pain.
-Intake #013989-19 related to Prevention of Abuse, Neglect and Retaliation and Skin and Wound Care.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Office (CEO), Vice President of Nursing and Clinical Services (VP), Assistant Vice President of Nursing and Clinical Services (AVP), a Registered Dietician (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Personal Support Workers (PSW), family members and a resident.

In addition, the Inspector reviewed residents' health care records and documents related to the home's investigations, an email, Mandatory Training and the home's policies related to Skin and Wound Care and Prevention and Reporting of Resident Abuse and Neglect. The Inspector observed resident care environments and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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	Légende 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when a resident is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietician who is a member of the staff of the home, and any change to the resident's plan of care relating to nutrition and hydration are implemented.

On an identified date, the Ministry of Long-Term Care Infoline received concerns from resident #002's family member alleged that a PSW in the home was aggressive towards the resident and the resident sustained an injury to a specific body area.

In an interview with the Registered Dietician (RD) on an identified date, stated that resident #002's altered skin integrity on a specific body area discovered on an identified date was not assessed by a RD since a referral was not received by the registered nursing staff.

The licensee as failed to ensure that resident #002's altered skin integrity on a specific body area discovered on an identified date, was assessed by a RD. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically

indicated.

Review of resident #002's health care records indicated that a clinically appropriate skin and wound assessment for the resident's altered skin integrity on a specific body area was performed on an identified date.

In an interview with RPN #112 on an identified date, validated that the resident's altered skin integrity to the specific body area was not reassessed the following week, by a member of the registered nursing staff.

In an interview with the Vice President of Nursing and Clinical Services on an identified date, stated that a skin and wound assessment for altered skin integrity should be performed weekly and resident #002's altered skin integrity to the specific body area was not assessed the following week.

The licensee has failed to perform a skin and wound assessment weekly for resident #002's altered skin integrity to a specific body area that was discovered on an identified date. [s. 50. (2) (b) (iv)]

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 when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietician who is a member of the staff of the home, and any change to the resident's plan of care relating to nutrition and hydration are implemented, to ensure when a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

On an identified date, inspector #551 received a concern from resident #001's Substitute Decision Maker (SDM) alleging that an identified equipment was not available when needed.

Review of resident #001's health care record written by RPN #108 on an identified date, indicated that a family member brought an identified meal. The resident's face became pale while being feed by the family's member. The resident was sweating, short of breath and there was wheezing sound. The notes indicated that the position of the specific device was immediately changed, and food was removed from the mouth. The registered nurse was called, and the identified equipment was not available.

In an interview with RPN #100 on a specific date, stated that the identified equipment was unavailable in the medication room on the identified unit. RPN stated that each unit should have their own identified equipment, but sometimes they are not functioning or being borrowed by the other unit.

In an interview with RPN #105 on a specific date from a different unit showed that the identified equipment was available in the medication room. Inspector #756 revealed that two of the identified equipments were in the medication room.

In an interview with RPN #106 on a specific date, demonstrated that the identified equipment was in the medication's room in another unit. RPN #106 searched for a specific pieces for the identified equipment, but they were unavailable. RPN #106 stated that the specific pieces for the equipment should be found in the storage room in the basement.

In an interview with RPN #102 on a specific date, demonstrated that the identified equipment was placed on a cart in the medication room in another unit. RPN #102 stated that an identified piece should have been connected to the equipment. RPN #102 revealed that the identified piece required for the equipment was not available in the medication room and should have been stocked nearby in case a resident needed the

specific intervention.

In an interview with RPN #101 on a specific date, indicated that the identified equipment should be kept in the medication room. RPN #101, inspectors #211 and #756 observed that the identified equipment was not available in the medication room from another different unit.

In an interview with RN #109 on a specific date, RN stated that the identified equipment will be found in the medication room or the clean utility room depending of the units. RN #109, Inspectors #211 and #756 observed that the equipment was not available in the medication room on that unit. The identified equipment was observed in the clean utility room after RN #109 asked RN #103 for the equipment's location.

In an interview with RPN #108 on a specific date, confirmed that the identified equipment was not readily available at the home to meet the nursing and personal care needs of resident #001 on an identified date.

In an interview with the Assistant Vice President of Nursing and Clinical Services (AVP) on a specific date, stated that the identified equipments should be found in the medication room or the clean utility room depending of the units. AVP expressed that the staff should ensure that the identified equipment be cleaned, readily available and accessible for each unit. [s. 44.]

Issued on this 3rd day of September, 2019

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

Original report signed by the inspector.