Ontario

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 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
Nov 26, 2019	2019_770178_0025	013417-19, 013653-19, 014432-19, 014482-19, 020985-19	Critical Incident System

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

SUSAN LUI (178), LISA CUMMINGS (756), MARK MCGILL (733)

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): November 12, 13, 14, 15, 19, 20, 2019.

The following Critical Incident Logs were inspected:
-014482-19/CIR #C569-000030-19 regarding alleged neglect of a resident
-014432-19/CIR #C569-000028-19 regarding alleged improper/incompetent treatment of a resident
-013417-19/CIR #C569-000023-19 and 013653-19/CIR #C569-000026-19 regarding alleged resident to resident abuse
-020985-19/CIR #C569-000047-19 regarding a fall that causes injury to a resident.

Non compliance to section 6(7) was identified during inspection of Log #014482-19/CIR #C569-000030-19 regarding alleged neglect of a resident, and the findings will be reported in Complaint Inspection Report #2019_770178_0024, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Restorative Care PSW, Behavioural Support PSWs, the Clinical Educator RN, the Assistant Vice President Nursing and Clinical Services, the Vice President Nursing and Clinical Services, the Staffing Coordinator, the Human Resources Coordinator, the Human Resources Manager.

During the course of the inspection, the inspectors also observed residents, resident care, resident home areas; reviewed resident health records, licensee records, including records of investigations, policies, and training records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
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)
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	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 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. This non compliance is in regards to Log #014432-19/CIR #C569-000028-19.

The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent care of resident #008 that resulted in harm to the resident, did immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act.

Critical incident Report (CIR) # C569-000028-19 was submitted by the licensee to report an incident of improper/incompetent treatment of a resident that resulted in harm or risk to a resident. The alleged incident of improper/incompetent treatment involved resident #008, who sustained a laceration while a mechanical lift sling was being applied to the resident. The incident was reported to the Director under the Long-Term Care Homes Act three days after it occurred.

The Vice President of Nursing indicated to Inspector #178 that the incident was not reported immediately because they thought it was not required as it did not initially cause a significant change in the resident's condition. The Vice President of Nursing indicated that they later realized it should have been reported immediately because it was an incident that happened as a result of the actions of a staff member who should have been more careful. [s. 24. (1)]

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 a person who has reasonable grounds to suspect improper or incompetent treatment or care of a resident that results in harm or a risk of harm to a resident, immediately reports the suspicion and the information upon which it is based to the Director under the Long-Term Care Homes Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #008.

This non compliance is in regards to Log #014432-19/CIR #C569-000028-19.

The plan of care for Resident #008 was reviewed and indicated that the resident required transfer with a mechanical lift and two assistants.

Critical Incident Report (CIR) # C569-000028-19 indicated that while the lift sling for the mechanical lift was being positioned under resident #008, a Personal Support Worker (PSW) from an identified staffing agency pulled the lift sling in a way which caused an identified skin injury to resident #008. The CIR indicated that resident #008 had fragile skin in the area of the injury.

An interview with PSW #116, who was present when resident #008 sustained the skin injury, indicated that they and PSW #122 were positioning the lift sling under resident #008, and PSW #122 pulled the lift sling in a way which caused a skin injury to resident #008. PSW #116 indicated that resident #008's skin is very fragile.

As such, the licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting resident #008. [s. 36.]

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 staff uses safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when required to inform the Director under the Long-Term Care Homes Act of an incident, a report was made in writing to the Director setting out a description of the individuals involved in the incident, including the names of any staff members or other persons who were present at or discovered the incident.

This non compliance is in regards to Log #014432-19/CIR #C569-000028-19.

Critical incident Report (CIR) # C569-000028-19 was submitted by the home to report an alleged incident of improper/incompetent treatment of a resident that results in harm or risk to a resident. The CIR did not include the names of the two staff members who were present during the incident, and was not amended at a later date to include the names of the staff.

RN #100, who submitted CIR #C569-000028-19, indicated to inspector #178 that they did not include the names of the two staff members present at the incident because they submitted the CIR two days after the incident took place, and they did not know the names of the staff members who were present at the incident.

The Vice-President of Nursing indicated to inspector #178 that the names of the two staff members present during the critical incident should have been included in the CIR. [s. 107. (4) 2.]

Issued on this 5th day of December, 2019

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

Original report signed by the inspector.