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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2019	2019_770178_0024	020870-19	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

SUSAN LUI (178)

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

Complaint Log #020870-19, regarding a complaint about resident care, was inspected.

Critical Incident Inspection #2019_770178_0025 was conducted concurrently with this complaint inspection, and a finding of non compliance from that inspection will appear on this report.

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

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in the plan of care was provided to resident #002 as specified in the plan.

Review of the health record indicated that resident #002 required a specified treatment to be provided twice daily at specified times.

Family member #125 indicated to Inspector #178 that the specified treatment for resident #002 was not completed as per the resident's plan of care on three specified dates. The family member indicated that on one specified date, resident #002 received the specified treatment only once, rather than twice as per their plan of care. The family member indicated that on two other specified dates, resident #001 received the specified treatment hours later than directed on the resident's plan of care.

Resident #002's electronic treatment record for the three specified dates was reviewed and indicated that the resident was to have received the specified treatment twice daily, at specified times. The treatment record indicated that on one specified time and date, the resident did not receive the specified treatment because they were sleeping. Resident #002's electronic progress notes indicated that on two other specified dates, resident #002's specified treatment was provided hours later than directed on the plan of care.

RPN #101 indicated to Inspector #178 that on one specified date, resident #002 received their specified treatment approximately three hours after the time specified in the plan of care because the PSW staff misunderstood the RPN and did not prepare the resident for the specified treatment as necessary, so the treatment was delayed. RPN #115 indicated to Inspector #178 that on a specified date, resident #002 received their specified treatment late because by the time the RPN realized the resident required the treatment, the resident was involved in another activity, so the treatment was delayed.

As such, the licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan. [s. 6. (7)]

2. The following finding of non compliance is from CI Inspection #2019_770178_0025, which was conducted concurrently with this complaint inspection.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

This non compliance is in regards to Log #014482-19/CIR #C569-000030-19.

A Critical Incident Report (CIR) #C569-000030-19 was submitted by the home on an identified date. The family and resident alleged that when the resident called for assistance with toileting, the staff member answering the call bell went to search for another staff member to assist with transfer and returned shortly stating "sorry you are out of luck, everyone is on break, you will have to wait until the evening crowd comes in (approximately 90 minutes later)". The resident stated that they waited until 1500h when their needs were met although they were in a lot of discomfort. A review of Resident #001's care plan at the time of the incident revealed that they required two staff assist - extensive assistance with an identified mechanical lift to transfer to the commode after lunch.

In an interview with Inspector #733, the Assistant Vice President (AVP) Nursing #102 indicated that resident #001 waited approximately two hours for care on an identified date. This was corroborated by the Human Resources Manager #105 in a subsequent interview where it was stated that the resident did not receive timely care and that they told a consistent story even after multiple interviews from staff.

The licensee has failed to provide care as specified in the plan of care. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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.