Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 7, 2020	2020_730593_0001	022489-19	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

GILLIAN CHAMBERLIN (593)

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): January 2, 6 - 7, 13, 15 - 16, 2020.

Log # 022489-19 was inspected, related to concerns regarding personal care, complaint responses and resident supervision.

During the course of the inspection, the inspector(s) spoke with the Administrator, Vice President of Nursing, Assistant Vice President of Nursing, Registered Nursing staff, Personal support workers (PSW's), residents and family members.

The Inspector observed the provision of care and services to residents, resident to resident interactions, staff to resident interactions, residents' environment and reviewed resident health care records and licensee policies.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care, was documented.

A complaint was received through the Action Line on behalf of a family member of resident #001. It was alleged that resident #001 was admitted for dental extraction of two teeth however all their teeth had to be removed as they were badly decayed. It was alleged that the teeth had not been brushed for at least a year.

A review of resident #001's documented care plan, said the following:

• Personal hygiene- requires 1 x staff for total assist with oral care with electric toothbrush twice daily and PRN (as needed).

Resident #001's dental hygiene task records were reviewed for a period of one year:

Month 1- during this month, there were two days where dental hygiene was not documented, and 18 days dental hygiene was recorded once.

Month 2- during this month, there was 17 days where dental hygiene was recorded once.

Month 3- during this month, there were seven days where dental hygiene was not documented, and 12 days dental hygiene was recorded once.

Month 4- during this month, there were six days where dental hygiene was not documented, and 16 days dental hygiene was recorded once.

Month 5- during this month, there were five days where dental hygiene was not documented, and 18 days dental hygiene was recorded once.

Month 6- during this month, there were four days where dental hygiene was not documented, and 16 days dental hygiene was recorded once.

Month 7- during this month, there were six days where dental hygiene was not documented, and 12 days dental hygiene was recorded once.

Month 8- during this month, there were eight days where dental hygiene was not documented, and nine days dental hygiene was recorded once.

Month 9- during this month, there were eight days where dental hygiene was not documented, and 16 days dental hygiene was recorded once.

Month 10- during this month, there were 12 days where dental hygiene was not documented, and 18 days dental hygiene was recorded once.

Month 11- during this month, there were 11 days where dental hygiene was not documented, and 17 days dental hygiene was recorded once.

Month 12- during this month, there were 10 days where dental hygiene was not documented, and 16 days dental hygiene was recorded once.

During an interview with Inspector #593, January 6, 2020, PSW #100 indicated that resident #001 cannot do any care by themselves. They added that it was difficult to do their oral hygiene prior to the surgery however the care was always done. PSW #100 added that the care was done but the records were not always completed to indicate that the care was done.

During an interview with Inspector #593, January 15, 2020, PSW #103 indicated that resident #001 is total care. They added that the resident can be resistive during oral care and sometimes two persons are needed to complete their care but the care is always done. PSW #103 added that when they have agency staff working on the floor, they are

not always charting that the care is completed, as required.

During an interview with Inspector #593, January 7, 2020, RPN #101 indicated that they were unsure if the care completed by PSWs was documented as they did not check the PSW documentation.

Inspector #593 reviewed the documentation for two additional residents:

Resident #002's dental hygiene task records were reviewed for a period of three months:

Month 1- during this month, there were 15 days where dental hygiene was not documented, and 11 days dental hygiene was recorded once.

Month 2- during this month, there were 16 days where dental hygiene was not documented, and 11 days dental hygiene was recorded once.

Month 3- during this month, there were 14 days where dental hygiene was not documented, and 17 days dental hygiene was recorded once.

Resident #003's dental hygiene task records were reviewed for a period of three months:

Month 1- during this month, there were nine days where dental hygiene was not documented, and 13 days dental hygiene was recorded once.

Month 2- during this month, there were nine days where dental hygiene was not documented, and 11 days dental hygiene was recorded once.

Month 3- during this month, there was 13 days where dental hygiene was not documented, and 11 days dental hygiene was recorded once.

During an interview with Inspector #593, January 15, 2020, PSW #103 indicated that resident #002 and #003 can be resistive during oral care but the care is always completed. PSW #103 added that when they have agency staff working on the floor, they are not always charting that the care is completed, as required.

PSW staff that provide direct care to residents #001, #002 and #003 indicated that the oral hygiene care was completed however the documentation was not always consistently completed. As such, the licensee has failed to ensure that the care provided

to residents #001, #002 and #003 was documented. [s. 6. (9) 1.]

2. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the residents care needs changed, or the care set out in the plan of care was no longer necessary.

A complaint was received through the Action Line on behalf of a family member of resident #001. It was alleged that resident #001 was admitted for dental extraction of two teeth however all their teeth had to be removed as they were badly decayed. It was alleged that the teeth had not been brushed for at least a year.

A review of resident #001’s documented care plan prior to the surgery, said the following:

• Personal hygiene- requires 1 x staff for total assist with oral care with electric toothbrush twice daily and PRN (as needed).

A review of resident #001’s documented care plan after the surgery, said the following:

• Personal hygiene- requires 1 x staff for total assist with oral care with electric toothbrush twice daily and PRN (as needed).

During an interview with Inspector #593, January 15, 2020, PSW #103 indicated that since the surgery, oral care was now done with a swab and prior to the surgery it was done with a regular toothbrush. PSW #103 added that sometimes their will be an agency PSW in the group that provides care to resident #001 that would need to refer to the documented plan of care for clarification.

During an interview with Inspector #593, January 16, 2020, the DOC indicated that it was the unit RPN who was responsible for reviewing and revising the residents documented care plan.

Two months post-surgery, resident #001's oral care requirements have changed however the residents plan of care does not document these requirements. As such, the licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the residents care needs changed. [s. 6. (10) (b)]

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 provision of care set out in the plan of care, is documented and the resident is reassessed and the plan of care reviewed and revised when the residents care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or staff member concerning the care of a resident is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

A complaint was received through the Action Line on behalf of family member #004. It was alleged that resident #001 was admitted for dental extraction of two teeth on November 6, 2019 however all their teeth had to be removed as they were badly decayed. It was alleged that the teeth had not been brushed for at least a year.

During an interview with Inspector #593, January 13, 2020, family member #004 indicated that after raising their concerns with staff members of the home shortly after the total dental extraction, they have not received any response or follow-up verbally or in writing from the home.

During an interview with Inspector #593, January 15, 2020, RN #103 indicated that family member #004 brought forward concerns about resident #001's oral hygiene shortly after the surgery. RN #103 indicated that they did not follow up with the family member nor communicate the concerns to management.

During an interview with inspector #593, January 6, 2020, the Assistant Vice President of Nursing indicated that family member #004 did not submit a formal complaint however they knew they were upset about the mouth care provided as they communicated this to the Assistant Vice President of Nursing, the day that resident #001 was discharged from hospital. They added that the family member brought in several devices provided by the Ottawa Civic to help with mouth care and they were told that this was being investigated. The Assistant Vice President of Nursing indicated that no other response or follow up was provided to family member #004 in relation to their concerns around dental care. [s. 101. (1) 1.]

Issued on this 7th day of February, 2020

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

Original report signed by the inspector.