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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347 rue Preston bureau 420
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 19, 2020	2020_593573_0014	005735-20, 006226-20, 008756-20, 009562-20, 015320-20	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

ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)

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): August 24 – 28 and 31, 2020.

The following Critical Incident Logs were inspected:

- Log #006226-20 and log #008756-20 regarding a fall incident that caused injury to a resident.

- Log #005735-20, log #009562-20 and log #015320-20 regarding alleged improper/incompetent care of a resident.

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, Registered Physiotherapist, the Human Resources Manager and the Vice President Nursing and Clinical Services.

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:
Falls Prevention
Personal Support Services
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **1 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. 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 the staff use safe transferring techniques when assisting with the residents' transfers.

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care

(MLTC), that described resident #001 sustained injury during transfer from wheelchair to bed and that the resident was send to the hospital for further management.

Inspector #732 spoke to PSW #107 who told Inspector that they transferred resident #001 from the wheelchair to bed, according to the resident's care plan, using a two-person side-by-side transfer, with the assistance of PSW #100. Both PSW #107 and PSW #100 told Inspector #732 that they noticed the injury once the resident was in their bed and that they were unsure how the resident sustained the injury.

RPN #108, who was immediately notified and assessed resident #001's injury and the resident surroundings, described to Inspector #732 that they believed the injury occurred during the resident's transfer.

The Vice President Nursing explained to Inspector #732 that it was determined the injury occurred during the resident's transfer from the wheelchair to bed.

A subsequent CIR for resident #001 was submitted to the MLTC Director, that described the resident sustained an injury during mechanical lift transfer.

Review of progress note written by RN #111, described that the injury was caused during transfer. Both PSW #101 and PSW #106 told Inspector #732 that they transferred resident #001 together, from the resident's bed into their wheelchair, using the mechanical lift and that the injury was not noticed until resident #001 was sitting in their wheelchair.

The Vice President of Nursing confirmed that the injury occurred during transfer and explained that staff need to be careful and cognizant of the residents' body parts during the transfer.

2. A CIR indicated that resident #004 had a fall and sustained an injury. Further, the CIR indicated that the fall incident occurred while a PSW #112 transferred resident #004 from the toilet to the wheelchair.

Inspector #573 reviewed resident #004's plan of care for the transfers at the time of incident which indicated that the resident required two staff members assistance for transfers. Inspector reviewed the PSW documentation for resident #004's transfers for two specified months in 2020. Upon review, there was multiple documentation by several PSWs on both shifts that indicated the resident was transferred with one staff member

assistance.

Inspector #573 spoke with PSW #112, who indicated that they transferred resident #004 from the toilet to the wheelchair without the second staff member assistance. Further, the PSW stated that they did not to follow the safe transferring techniques while assisting resident #004.

Inspector #573 spoke with the Vice President of Nursing, who stated that an investigation was completed for the incident. Furthermore, they stated that PSW #112 failed to follow proper safe transferring techniques with two staff members assistance while transferring resident #004.

Therefore, the licensee failed to ensure that staff use safe transferring techniques when assisting with resident #001 and resident #004's transfers. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with section 76.(4) of the Long-Term Care Homes Act in that the licensee failed to ensure that the persons who received training under subsection (2) receive retraining in the areas mentioned in that subsection at intervals provided for in the regulations.

In accordance with this section, section 76.(2)11.of the Act, and sections 218.2. and 219. (1) of the regulation, the licensee is to ensure that all staff at the home have received training on the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities. Such training is to be provided prior to a staff member performing their responsibilities and annually thereafter.

PSW #100 was involved in an incident where resident #001 sustained an injury during transfer. The Vice President of Nursing provided Inspector #732 with a list of staff who had completed their residents Lift and Transfer training/ education for 2019. PSW #100 was not on the provided list. PSW #100 told Inspector #732 that they had received training on lifts and transfers upon hire to the long-term care home but had not had any retraining since.

2. PSW #112 was involved in an incident where resident #004 sustained an injury during transfer. Inspector #573 reviewed the list of staff who had completed their annual residents Lift and Transfer training/ education for 2019. Upon review, it was noted that PSW #112 did not received their annual residents Lift and Transfer training/ education in 2019.

Inspector #573 spoke with the Human Resources Manager and the Vice President of Nursing, both could not confirm that PSW #112 received their annual residents Lift and Transfer training/ education in 2019. Furthermore, the Human Resources Manager stated that out of 238 nursing staff 68 (29%) of them did not completed their annual residents Lift and Transfer training/ education in 2019.

As such, the licensee failed to ensure that the persons who received training under subsection (2) received retraining annually on the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids. [s. 76. (4)]

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 receive annual retraining on the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities, to be implemented voluntarily.

WN #3: 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that the improper care of resident #001, that resulted in harm to the resident, was immediately reported to the Director.

A CIR was submitted to the MLTC Director, under the category improper/incompetent treatment of a resident that results in harm or risk of harm to a resident. The CIR described that resident #001 had an injury during mechanical lift transfer. Resident #001 was sent to the hospital for further management.

The Vice President of Nursing acknowledged that the CIR was not submitted immediately and told Inspector #732 that the on-call manager was not called on the evening the incident occurred and that it was the Registered Nurse on the next evening shift who submitted the CIR report.

Therefore, the Director was not immediately made aware of the improper care that resulted in harm to resident #001. [s. 24. (1) 1.]

Issued on this 22nd day of October, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ANANDRAJ NATARAJAN (573), EMILY BROOKS (732)
Inspection No. / No de l’inspection :	2020_593573_0014
Log No. / No de registre :	005735-20, 006226-20, 008756-20, 009562-20, 015320-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 19, 2020
Licensee / Titulaire de permis :	St. Patrick's Home of Ottawa Inc. 2865 Riverside Drive, OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	St. Patrick's Home 2865 Riverside Drive, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Janet Morris

To St. Patrick's Home of Ottawa Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee must be compliant with section 36 of Ontario Regulation (O. Reg.) 79/10. Specifically, the licensee must:

(1) Ensure that all PSWs and Registered Nursing staff, receive retraining regarding the licensee's policy on safe lifting, transferring and repositioning of residents.
The training must include, but not limited to:
a. Demonstration of different methods/techniques of the resident transfers and how to perform them safely.
b. Demonstration of safe resident handling and proper maneuvering of all the mechanical lifts used in the home for the resident transfers.
c. Keep a record of the training, including the date and the persons who attended.

(2) Ensure that staff use safe transferring techniques to assist resident #001 and all residents who require assistance with transferring as specified in the resident's plan of care.

(3) Perform weekly audits on PSW #100, #101, #106, #107 and #112 to ensure they are transferring residents according to the licensee's policy on safe lifting, transferring and repositioning of residents; and

(4) Document the audits and continue auditing until no further concerns arise with the PSWs transferring residents in accordance with the licensee's policy.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff use safe transferring

techniques when assisting with the residents' transfers.

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care (MLTC), that described resident #001 sustained injury during transfer from wheelchair to bed and that the resident was send to the hospital for further management.

Inspector #732 spoke to PSW #107 who told Inspector that they transferred resident #001 from the wheelchair to bed, according to the resident's care plan, using a two-person side-by-side transfer, with the assistance of PSW #100. Both PSW #107 and PSW #100 told Inspector #732 that they noticed the injury once the resident was in their bed and that they were unsure how the resident sustained the injury.

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The Vice President of Nursing confirmed that the injury occurred during transfer and explained that staff need to be careful and cognizant of the residents' body parts during the transfer. (732)

2. A CIR indicated that resident #004 had a fall and sustained an injury. Further, the CIR indicated that the fall incident occurred while a PSW #112 transferred resident #004 from the toilet to the wheelchair.

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Inspector #573 spoke with the Vice President of Nursing, who stated that an investigation was completed for the incident. Furthermore, they stated that PSW #112 failed to follow proper safe transferring techniques with two staff members assistance while transferring resident #004.

Therefore, the licensee failed to ensure that staff use safe transferring techniques when assisting with resident #001 and resident #004's transfers.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it was related to all three incidents reviewed. The home had a level 3 compliance history as they had on-going non-compliance with this section of Ontario Regulation 79/10, including:
• Voluntary Plan of Correction (VPC) issued June 25, 2018 (2018_617148_0016);
• VPC issued May 8, 2019 (2019_665551_0008);
• VPC issued September 9, 2019 (2019_618211_0019);
• VPC issues November 26, 2019 (2019_770178_0025)

(573)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 31, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Anandraj Natarajan

Service Area Office /
Bureau régional de services : Ottawa Service Area Office