Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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

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

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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
Jan 26, 2021	2020_548756_0024	019952-20, 020067-20, 020116-20, 021647-20, 024354-20, 024768-20	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

LISA CUMMINGS (756), EMILY PRIOR (732)

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): December 23, 24, 29, 30, 2020, and January 4-6, 2021.

During this complaint inspection the following intakes were inspected:
- Log #021647-20: A complaint regarding medication administration and assistance with meals
- Log #024768-20: A complaint regarding the noise level in the home
- Log #024354-20: A complaint regarding infection prevention and control practices
- Log #020067-20: A complaint regarding the visitation policy and resident responsive behaviours
- Log #020116-20: A complaint regarding an allegation of resident abuse
- Log #019952-20: A critical incident (CI #3015-000026-20) regarding an allegation of resident abuse

During the course of the inspection, the inspector(s) spoke with the President, the Vice President of Nursing, the Assistant Vice President of Nursing, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary staff, a private care provider, and residents.

During the course of the inspection, the inspectors reviewed several resident healthcare records and licensee internal investigation notes, and observed the provision of resident care and services including meals, medication administration and infection prevention and control practices, observed resident home areas and resident rooms, and observed the interactions between residents and between residents and staff members.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to the resident unless the drug had been prescribed.

An RPN was completing the medication pass and asked a second RPN for assistance administering a resident's medication. The second RPN administered a medication cup prepared for a co-resident, which caused the resident to be administered 3 medications that were not prescribed for them. Following the medication error, the physician was notified and the resident was monitored.

The RPN acknowledged they misunderstood the direction from their colleague and administered the prepared medication in error.

Sources: a resident healthcare record, licensee's internal investigation notes, interviews with an RPN and other staff. [s. 131. (1)]

Issued on this 9th day of February, 2021

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

Original report signed by the inspector.