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

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 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
Mar 22, 2021	2021_593573_0006	021256-20, 025803-20, 026043-20, 001168-21, 002060-21	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)

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): February 23 – 25, 2021, March 1 – 5, 8 and 9, 2021.

The following logs were completed in this Critical Incident System (CIS) inspection: Log #025803-20, Log #026043-20 and Log #001168-21 were related to allegation of improper/ incompetent care of a resident that results in harm or risk to a resident. Log #002060-21 regarding a fall incident that caused injury to a resident.

Follow up log # 021256-20 CO #001 from Inspection 2020_593573_0014 related to safe transferring and positioning techniques (s. 36) with Compliance due date January 31, 2021 was inspected concurrently during this inspection.

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

During the course of the inspection the inspector reviewed the identified resident's health care records, observed video footage, reviewed licensee's internal investigation records and other pertinent documents. In addition, inspector observed the provision of care to the residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Training and Orientation

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

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2020_593573_0014	573

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that the written plan of care for the residents sets out the planned care for the residents.

A resident sustained an injury during a transfer. At the time of the incident, the resident's plan of care indicated that the resident was independent for the transfers with no assistive device and supervision as needed. Furthermore, the plan of care indicated that the resident was independent for mobility with no assistive devices.

A PSW stated that at the time of the incident, the resident was one-person physical assistance for transfers. Furthermore, the resident’s progress notes prior to the incident indicated that a loaner wheelchair was used for the resident’s mobility. This planned care related the resident’s transfer and mobility was not set out in the resident’s plan of care at the time of incident.

A resident’s plan of care indicated that the resident required one staff extensive assistance for applying their continent product and to complete the dressing. During an interview, the Vice President of Nursing stated that the resident was two-person physical assistance for the dressing due to their behaviours. This planned care was not set out in the plan of care.

Sources: Resident's plan of care, progress notes, interview with the PSW, the Vice President of Nursing and other staff members. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

The plan of care for the resident's responsive behaviour directed the staff to provide clear explanation prior to all care activities and during each contact of their care. The plan of care indicated that if the resident was resistive to care the staff to allow the resident to refuse and re approach. Furthermore, it stated that if the resident continues to resist for care the staff to report to the registered nursing staff.

The inspector reviewed video footage, whereby the resident was observed to be provided with the care. Two PSWs provided the care to the resident. The video footage showed that while providing care, the PSWs failed to provide clear explanation prior to the care and during each contact of their care. Furthermore, when the resident was resistive to care the PSWs failed to re approach and report to the registered nursing staff.

Sources: The resident's plan of care, progress notes, resident's video footage, and interview with the Vice President of Nursing. [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 written plan of care for each resident sets out the planned care for the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to the use of Personal Protective Equipment (PPE).

The Chief Medical Officer of Health (CMOH) Directive #1 for Health Care Providers and Health Care Entities (Revised March 30, 2020), CMOH Memo: Directive # 3 for Long-Term Care Homes (December 07, 2020), COVID-19 Guidance: LTC Homes, version 4, April 15, 2020, Guidance for mask use in LTC homes and retirement homes, version 1-April 15, 2020, and Personal Protective Equipment (PPE): Guidance for the LTC & RH Sectors, Version 1.0, April 20, 2020, all long-term care home staff are to wear face masks at all times when in a long-term care home.

During an observation of the home area, the inspector observed a PSW was not wearing their face mask in the resident's dining area. A resident and a staff member were noted in the dining area. On another home area, the inspector observed another PSW in the resident's dining area, talking in the phone with out covering their mouth with a face mask.

The licensee has failed to ensure that staff participate in the implementation of the Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, "Just Clean Your Hands (JCYH)".

During the lunch meal service, the inspector observed a PSW who assisted the residents with their meals did not perform their hand hygiene nor washed their hands between the care. Furthermore, the home's HH program did not include a process for the staff to assist the residents to clean their hands before and after a meal as residents' hands were not cleaned before and after the lunch.

Sources: Direct observations, interviews with the PSWs, the Vice President of Nursing and other staff interviews. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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 failed to ensure that staff used safe transferring and positioning techniques when assisting with the residents.

A resident sustained an injury during a one-person physical assist transfer by a PSW. Inspector reviewed the resident's health care records and spoke with the staff members related to the incident. The staff members and the V.P Nursing all confirmed that the PSW did not follow safe transferring techniques, when assisting the resident's transfer.

The inspector reviewed video footage, whereby a resident was observed to be provided with the care. Two PSWs provided the care and positioned the resident on the bed. The video showed that while providing care, the PSWs failed to ensure that proper and safe positioning techniques were used when assisting with the resident's care.

A Compliance Order #001 in relation to s.36 was issued on October 19, 2020, with the compliance date on January 31, 2021, by Inspector #573 in Inspection Report #2020_593573_0014.

Sources: licensee's internal investigation records, the resident's video footage, interview with a PSW, an RPN and the Vice President of Nursing. [s. 36.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that the medication room, where drugs are stored were kept locked at all times, when not in use.

During an observation of the home area, on two units the inspector observed the medication room near the resident lounge/ dining area, was open and unsupervised. Inspector spoke with the respective RPNs on the unit, both stated that the medication room should not have been left open, as they were not in use.

Sources: Direct observations, the RPNs interview, and the Assistant Vice President of Nursing. [s. 130. 1.]

Issued on this 8th day of April, 2021

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

Original report signed by the inspector.