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
May 13, 2022	2022_548756_0006	018773-21, 020555-21, 000523-22, 000581-22, 001452-22, 001982-22	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

LISA CUMMINGS (756), GURPREET GILL (705004), PAMELA FINNIKIN (720492)

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): March 9, 10, 14, 15, 16, 17, 21, 22, 23, 24, 2022.

The following intakes were completed during this Critical Incident System (CIS) inspection:
- Log #018773-21 for CIS #3015-000037-21, and log #020555-21 for CIS #3015-

000038-21, regarding incidents that caused injury to the resident for which the resident was taken to hospital and resulted in a significant change in health status
- Log #000523-22 for CIS #3015-000001-22, regarding an allegation of improper care of a resident
- Log #000581-22 for CIS #3015-000002-22, and log #001982-22 for CIS #3015-000005-22 regarding allegations of verbal and physical abuse of a resident
- Log #001452-22 for CIS #3015-000003-22, regarding an unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Vice President of Nursing (VP of Nursing), the Assistant Vice President of Nursing (AVP of Nursing), the Clinical Educator, the Manager of Support Services, the Records Management Coordinator, the Wound Care Champion, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, the provision of care and services, the entrance of the home and resident home areas, and Infection Prevention and Control Practices. A review of relevant records was completed including resident health records, internal investigation notes, daily housekeeping routines, and policies; Head Injury Routine Flowsheet (Policy #IX NSG E-11.00(a) – Appendix A), Head Injury Routine (HIR) (Policy #IX NSG E 11.10, revised April 2021), Fall Prevention and Management (Policy #IX NSG E-11.00, revised April 2016), Skin and Wound Care (Policy #IX NSG E 12.00, revised March 2019), Referral to Dietitian (Policy #X NTN C-10.68, revised September 2013), Pain and Symptom Management (Policy #IX NSG E 10.00, revised April 2021), and Infection Prevention and Control Program (Policy #IX NSG J 10.00, revised September 2017).

A non-compliance under Ontario Regulation 79/10 s. 8 (1) (b) will be reflected under concurrent inspection report #2022_548756_0005.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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)**

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received an assessment by a Registered Dietitian.

The resident was sent to hospital after a witnessed fall and sustained injuries that included altered skin integrity.

A review of the resident's health care record indicated that no assessment was completed by a Registered Dietitian upon the resident's return from hospital as a result of the injuries.

VP of Nursing confirmed that a Registered Dietitian referral was not completed for the resident upon return from hospital and verified that a Registered Dietitian referral should be completed for all residents returning from hospital with altered skin integrity.

A review of the home's Skin and Wound Care Policy confirmed that for management of altered skin integrity, an assessment by a Registered Dietitian is completed. A review of the home's Referral to Dietitian Policy confirmed that residents who return from the hospital are to be referred to the Registered Dietitian.

Sources: Resident #001 health care records, the skin and wound care policy, the

Referral to Dietitian Policy and interview with the VP of Nursing. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that resident #001 received a reassessment at least weekly by a member of the registered nursing staff for altered skin integrity.

The resident was sent to hospital after a witnessed fall and sustained injuries that included altered skin integrity.

A review of the resident's health care record indicated that no follow up skin and wound assessments were completed after the initial skin and wound care assessment upon the resident’s return from hospital.

A review of the home’s Skin and Wound Care Policy confirmed that for management of altered skin integrity, registered staff are to complete assessments at least weekly.

The Wound Care Champion confirmed that weekly follow up assessments are required for altered skin integrity.

Sources: Resident #001 health care records, Skin and Wound Care Policy and interview with the Wound Care Champion. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff and is assessed by a Registered Dietitian who is a member of the staff of the home, 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 staff participated in the implementation of the Infection Prevention and Control program regarding sanitizing high touch surfaces in hallways.

The daily housekeeping routine outlined that all high touch points in hallways were to be sanitized daily. A Housekeeper indicated that they sanitized the high touch surfaces in the hallways of one resident home area twice a week as they did not have enough time to complete this task daily.

The Manager of Support Services confirmed that sanitizing high touch surfaces in hallways should be completed daily.

Sources: Infection Prevention and Control Policy, the Daily Housekeeping Routine, interviews with a Housekeeper, the Manager of Support Services and other staff. [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 staff participate in the implementation of the infection prevention and control program including sanitizing high touch surfaces at least daily, to be implemented voluntarily.

WN #3: 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. (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 resident #006's plan of care was revised due to changes in the resident's care needs.

The resident had an unwitnessed fall which resulted in a transfer to the hospital where the resident was diagnosed with an injury. Upon the resident's return from the hospital, an assessment was completed by restorative care staff.

A review of the resident's plan of care confirmed that no updates were made by restorative care staff since the resident's return from hospital.

The RSW confirmed that the resident's plan of care was not updated after the assessment was completed.

The AVP of Nursing confirmed that the plan of care should be updated when changes are made by restorative care staff, and that the care plan for the resident was not updated after the assessment was completed by restorative care staff upon return from hospital.

Sources: Resident health care records, including the plan of care in Point Click Care, and interviews with an RSW and AVP of Nursing. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a critical incident no later than one business day after the occurrence of the incident, as required under O. Reg. s. 107 (4), subject to (3.1).

A CIS was submitted under O. Reg. s. 107 (3) (4) to report an incident of a fall with injury resulting in a transfer to hospital.

Resident #006 had an unwitnessed fall which resulted in a transfer to the hospital and diagnosed with an injury. The home was notified of the injury the following day but the CIS was not submitted until seven days later.

The AVP of Nursing confirmed that the CIS was submitted late.

Sources: CIS #3015-000038-21, resident health care record and interview with the AVP of Nursing. [s. 107. (3)]

Issued on this 26th day of May, 2022

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

Original report signed by the inspector.