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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 7, 2022
Inspection Number 2022_1510_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Patrick's Home of Ottawa Inc.

Long-Term Care Home and City
St. Patrick's Home, Ottawa

Lead Inspector
Susan Lui (178)

Inspector Digital Signature
Susan Lui
Digitally signed by Susan Lui
Date: 2022.09.08 14:50:02 -04'00'

Additional Inspector(s)
Megan MacPhail (551)
Lisa Cummings (756)
Sarabjit Kaur (740864)
Severn Brown (740785)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 11, 12, 15, 17, 19, 22-26, 29-31, Sept 7, 2022.

The following intake(s) were inspected:

- #010279-22 (Follow-Up) related to the falls prevention and management policy
- #011994-22 (Complaint) related to a resident transfer
- #012412-22 (Complaint) related to falls and alleged neglect
- #014540-22 (Complaint) related to resident care, Residents' Bill of Rights, and infection prevention and control
- #015573-22 (Complaint) related to a fall
- #006361-22 (CIS #3015-000020-22), #011875-22 (CIS #3015-000050-22), and #013314-22 (CIS #3015-000057-22) related to falls with injury
- #008357-22 (CIS #3015-000028-22) related to a resident injury
- #009380-22 (CIS #3015-000040-22) related to a resident injury
- #012422-22 (CIS #3015-000053-22) related to falls and alleged neglect
- #016142-22 (CIS #3015-000073-22) related to an unexpected death

The following intakes were completed during this inspection:

-#012564-22 (CIS #3015-000054-22), #011933-22 (CIS #3015-000051-22), #008963-22 (CIS #3015-000038-22), and #006392-22 (CIS #3015-000021-22), related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 8	2022_548756_0005	001	Susan Lui (178)

The following **Inspection Protocols** were used during this inspection:

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Residents' Rights and Choices
- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6. (10) (b)

1) A resident's Minimum Data Set (MDS) assessment indicated the resident required two-person extensive assistance for transfers and walking. A Physiotherapy Assistant (PTA) and a Restorative Care PSW confirmed these were the resident's current care needs. The resident's care plan did not reflect this assessment and indicated the resident required one person assistance with transfers and was independent with walking in the room and corridor.

The care plan was updated to reflect the resident's current assessed needs for transfers and walking in the room and corridor.

Sources: MDS Assessment, resident care plan, transfer logo, interviews with a PTA, a Restorative Care PSW, and the Vice President (VP) of Nursing.

Date Remedy Implemented: August 31, 2022 [756]

2) The plan of care for a resident indicated that they should have a bed alarm when in bed. Observations and staff interviews indicated that a bed alarm was not currently required or used for the resident.

Before the conclusion of the inspection the plan of care was revised to reflect the resident's current care needs, and the bed alarm was removed from their plan of care.

Sources: Clinical health record for a resident; Interviews with the VP of Nursing and other staff.

Date Remedy Implemented: August 30, 2022 [178]

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6. (7)*

1) The licensee has failed to ensure staff followed a resident's plan of care related to falls prevention and self care performance deficit.

Rationale and Summary

A) A resident's self performance deficit plan of care indicated that the resident should be transferred with the assistance of two staff. The resident fell and was on the floor for approximately one hour before being discovered by an agency supplied companion. When the companion discovered the resident on the floor, they picked the resident up without assistance and returned the resident to their bed without informing the nurse or any home staff that the resident had fallen. The resident was not transferred with the appropriate level of assistance required in their plan of care.

B) A resident's fall prevention plan of care indicated that the resident was to have comfort rounds conducted to assess the resident's comfort needs at least every two hours during the night. The resident also had an agency supplied companion assigned to them.

The resident fell and was on the floor for approximately four hours before they were observed by the companion or by the home's staff. Staff on the unit did not monitor and assess the resident's comfort needs at least every two hours as required by the resident's plan of care.

This non-compliance possibly caused mental and physical discomfort to the resident as they were left on the floor for a long period without the assistance they needed. The non-

compliance also caused risk of harm when a companion moved the resident inappropriately after they had fallen, and without assessment by a member of the registered nursing staff.

Sources: Interviews with the VP of Nursing and an RN; clinical health record for a resident; the licensee's investigative records.

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2) The licensee has failed to ensure that the plan for a resident to have tests completed after finishing a medication was provided as specified in the plan.

Rationale and Summary
A resident was diagnosed with a medical condition and was prescribed a medication for ten days.

The resident had a physician's order for tests to be completed after the ten day course of medication was finished. Progress notes showed a request from the Power of Attorney to complete a test eight days after the medication finished and this request was placed in the physician's communication book. Further progress notes indicated that staff first attempted to initiate testing eighteen days after the medication finished and were successful in completing the tests three days after this.

A Registered Nurse (RN) confirmed that there was no indication of an attempt prior to eighteen days after the medication was finished to initiate testing.

The resident was later transferred and admitted to hospital.

Sources: Physician's order, resident healthcare record, and an interview with an RN.

[756]

WRITTEN NOTIFICATION GENERAL REQUIREMENTS FOR PROGRAMS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 *s. 30 (2)*

The licensee has failed to ensure that a Registered Practical Nurse (RPN) recorded the neurological reassessment of a resident after their fall with head injury, as required by the licensee's Head Injury Routine policy.

Rationale and Summary
A resident fell and struck their head. An RPN responded to the resident and performed the post-fall assessment and initiated the Head Injury Routine (HIR) as per the licensee's policy.

The resident had two neurological assessments performed a half hour apart as per the requirements of the HIR form, with the third neurological assessment due to be performed an hour later. The RPN stated that they performed the third neurological assessment, and understood the HIR re-assessment requirements per the Fall Prevention and Management policy and how it was to be documented. Upon record review it was found that the third required neurological assessment was not documented. The RPN failed to document the third neurological examination they performed.

When the resident was next re-assessed as required by the HIR, they were found to have significant neurological changes from their last documented assessment.

Sources:
IX NSG E-11.10(a) Head Injury Routine-Appendix A.
Nursing Policy Manual: IX NSG E-11. 00 Fall Prevention and Management
Interview with the VP of Nursing and an RPN.

[740785]

WRITTEN NOTIFICATION REQUIREMENTS RELATING TO RESTRAINING BY A PHYSICAL DEVICE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 119. (2) 6.*

The licensee has failed to ensure that a resident's condition was reassessed, and the effectiveness of the restraint evaluated by a member of the registered nursing staff at least every eight hours.

Rationale and Summary
A resident had a device initiated as a restraint. Hourly monitoring was initiated at that time and was completed by Personal Support Workers (PSW).

When interviewed, two Registered Practical Nurses (RPN) did not identify the device for the resident as a restraint and indicated they did not reassess the resident's condition and effectiveness of the device at least every eight hours. One RPN stated this assessment would be documented in Point of Care (POC), however the resident was not identified in this system as having a restraint in place and therefore they did not complete the reassessment each shift.

The VP of Nursing confirmed the device was initiated as a restraint and that registered staff had not conducted a reassessment of the resident's condition and of the effectiveness of the device each shift.

Sources: Observation of the resident, resident health care record, and interviews with the VP of Nursing, and two RPNs.

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COMPLIANCE ORDER #001 PLAN OF CARE

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with FLTCA, 2021 s. 6(8)

The licensee shall:

A) Provide education to a PSW regarding:

-the meaning and use of transfer logos

-the requirement to familiarize themselves with a resident's plan of care before providing care.

B) A written record must be kept of this education until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: FLTCA, 2021 *s. 6 (8)*

The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary
A resident was walking in the hallway with an assistive device and a PSW. The resident fell and sustained multiple injuries which required hospitalization for assessment and care.

The resident's plan of care indicated that they could walk in their room with the assistance of one staff member and an assistive device, but to walk in the corridor they should have had a higher level of assistance. The PSW was providing care to the resident for the first time and was not aware that the resident required a higher level of assistance to walk in the corridor. The PSW indicated that they misunderstood the transfer logo posted in the resident's room which displayed one assist with an assistive device, to mean that the resident could walk in the hallway with that level of assistance. The PSW indicated they had not checked the plan of care for the resident before providing their care and had been unable to find the regular PSW working on that wing to ask questions about the resident's care needs.

This non-compliance caused actual harm as the resident sustained multiple injuries requiring hospitalization for assessment and care.

Sources: A resident's clinical health record; interviews with a PSW and the VP of Nursing.

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This order must be complied with by October 14, 2022

COMPLIANCE ORDER #002 SECURITY OF DRUG SUPPLY

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 139.1.

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22 s. 139.1.

The licensee shall:

A) Conduct audits, at least weekly, on the day and evening shifts to ensure that registered nursing staff are locking the medication cart and medication room when not in use. The audits are to be completed until consistent compliance is achieved.

B) Take immediate corrective action to address staff non-compliance with locking the medication cart and medication room when not in use.

C) A written record must be kept of everything required under (A) and (B) until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: O. Reg. 246/22 s. 139.1.

The licensee has failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

Rationale and Summary

1. The medication room door and the cart were observed on the Wexford unit on day shift. The medication cart was unlocked, and the medication room door was propped open without registered staff present. Residents were seated in the dining room, near the medication cart and medication room.

When an RPN Student returned to the medication cart and medication room, they stated they were only gone for a few minutes. The RPN student confirmed that they were supposed to lock the medication cart and ensure the door to the medication room is closed and locked when not in use.

Sources: Inspector Observations, Interview with an RPN student.

[740864]

2. The medication cart and the medication room were observed on the Kilkenny unit on evening shift. The medication cart was unlocked and the medication room door was propped open without registered staff present. Residents were seated in the dining room, near the medication cart and medication room.

When an RPN returned to the medication cart and medication room, they stated they were in a resident's room. The RPN confirmed they are supposed to lock the medication cart and ensure the door to the medication room is closed and locked when not in use.

Sources: Observation, interviews with an RPN and the VP of Nursing.

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3. The medication cart on Waterford unit was observed unattended outside the medication room on day shift. The medication cart was unlocked with the top drawer open approximately three centimetres. Staff members and multiple residents were nearby in the dining room at the time. An RPN was in the report room at the time, out of view of the medication cart.

The RPN exited the report room and approached the medication cart after approximately two minutes. The RPN indicated that they were responsible for keeping the medication cart locked when not in use, and they had left it unlocked while speaking to a physician inside the report room.

4. The medication room on Kerry unit was observed on day shift to be empty with the door propped open with a wedge. The RPN was in the common area near the piano at the time, out of view of the medication room.

The RPN returned to the medication cart accompanied by the writer approximately one minute later and indicated that they had gone around the corner to check a resident with a PSW and were briefly out of sight of the medication room.

The VP of Nursing confirmed that medication carts and rooms should be kept locked at all times when not attended.

Failure to lock the medication carts and medication rooms when not in use posed potential risk to residents, as medications were left easily accessible on various units and on different shifts.

Sources: Observations on Waterford and Kerry units; interviews with two RPNs and the VP of Nursing.

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This order must be complied with by October 14, 2022

REVIEW/APPEAL INFORMATION

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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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