Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Amended Public Report (A1)

Report Issue Date: January 30, 2023

Inspection Number: 2022-1510-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: St. Patrick's Home of Ottawa Inc.

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

Lead Inspector	**Inspector who Amended Digital Signature**
Anandraj Natarajan (573)	Anandraj Natarajan Digitally signed by Anandraj Natarajan Date: 2023.01.30 15:06:37 -05'00'

Additional Inspector(s)
Sarabjit Kaur (740864)
Severn Brown (740785)
Gurpreet Gill (705004)

AMENDED INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect amendment to the Inspection summary related to inspection number (#2022-1510-0001) under the previously issued Compliance Order(s). There is no change to the narrative of the finding(s) or the determination of compliance.

INSPECTION SUMMARY

The Inspection occurred on the following date(s): November 3, 4, 7 -10, 14 -17, 21 -25, 29 and 30, 2022 and December 1, 2022.

The following intake(s) were inspected:
· Intake: #00007352 – Follow-up on Compliance Order (CO) #001 served in inspection report #2022_1510_0001 regarding FLTCA, 2021 s. 6 (8), with a compliance due date of October 14, 2022.
· Intake: #00007353 – Follow-up on Compliance Order (CO) #002 served in inspection report #2022_1510_0001

regarding O. Reg. 246/22 s. 139, with a compliance due date of October 14, 2022.

- Intake: #00001025- [IL: IL-02157-OT] - Allegation of staff to resident abuse and neglect.
- Intake: #00001593 - Complaint /concerns related to care and services to the residents.
- Intake: #00012806-IL-06969-OT, IL-07056-OT, IL -07063-OT- Complaint /concerns related to care and services to the residents.
- Intake: #00012815-IL-06970-OT - Complaint /concerns related to care and services to the residents.
- Intake: #00001388- Fall of a resident resulting in an injury and transfer to the hospital.
- Intake: #00001720- Medication incident.
- Intake: #00002152- Injury to a resident with unknown cause.
- Intake: #00002706- Allegations of financial abuse to a resident.
- Intake: #00003320- Allegations of staff to resident improper care
- Intake: #00007306- Allegations of resident-to-resident physical abuse.
- Intake: #00010973- Allegations of resident-to-resident sexual abuse.
- Intake: #00012124- Allegations of staff to resident improper care.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022-1510-0001 related to FLTCA, 2021, s. 6 (8) inspected by Anandraj Natarajan (573)

Order #002 from Inspection #2022-1510-0001 related to O.Reg. 246/22, s. 139 1. inspected by Anandraj Natarajan (573)

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

Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Falls Prevention and Management
Responsive Behaviours
Staffing, Training and Care Standards
Resident Care and Support Services
Medication Management
Reporting and Complaints
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the Licensee's policy on Prevention and Reporting of Resident Abuse is complied with.

Rationale and Summary: Licensee's policy on Prevention and Reporting of Resident Abuse and Neglect I ADM G 10.03 revised in January 2022 indicates that all staff are required to immediately report any alleged or suspected or known incident of abuse or neglect to the RPN, RN, President/CEO or designate in charge of the home.

The plan of care of a resident identifies that the resident has inappropriate sexual behaviors towards co-residents. Progress notes by an RN indicates that there was an incident of alleged sexual abuse with the resident kissing a co-resident in the dining room and witnessed by a PSW.

The inspector spoke to the PSW, and they confirmed that the incident was not reported to the registered nursing staff immediately. The RN confirmed that the PSW did not report the incident immediately and reported on the next day.

Sources: Licensee's policy on prevention and Reporting of Resident Abuse and Neglect dated January 26, 2022, Resident's health care record, interview with the PSW and the RN. [740864]

WRITTEN NOTIFICATION: Plan of care - Duty of licensee to comply with plan

NC #002 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 that the care set out in the plan of care was provided to the resident, as specified in the plan.

Rationale and Summary: A resident fell from a wheelchair sustaining an injury and requiring transport to hospital. The resident's plan of care at the time of the incident indicates that they had a behaviors problem related to climbing on the furniture and required 24/7 one on one monitoring for safety.

Interviews with the RN and the RPN, stated that at the time of the fall the resident was left unattended. Failure to appropriately monitor the resident based on their care needs resulted in actual harm being caused to the resident.

Sources: Interviews with the RN and RPN, the resident's plan of care. [740785]

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.

Rationale and Summary: During this inspection, on two separate occasions the inspector observed a resident was not provided with a specified textured diet for their meal, as specified in their plan of care. In an interview, the Registered Dietitian confirmed that the resident should receive a specified texture diet as specified in their plan of care. The staff failed to provide the correct texture diet as specified in the resident plan of care which may pose potential risk of harm to the resident.

Sources: Inspector observations, resident's plan of care, interview with the Registered Dietitian and other staff. [573]

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1)

The licensee has failed to ensure that every written complaint made to the licensee or staff member concerning the care of a resident is investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint.

Rationale and Summary: An email from an resident's Substitute Decision-Maker (SDM) indicated that after the resident's fall incident, they have not received the results of the investigation from the Long-Term Care Home (LTCH).

During an interview with the Vice President (VP) of Nursing, they indicated that a response was not provided to the resident's SDM regarding their concerns related to the resident's fall incident.

Sources: Interview with the Vice President of Nursing and emails from the resident's SDM. [705004]

WRITTEN NOTIFICATION: Policies, etc., to be followed and records.

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 11 (1) (b)

The licensee has failed to ensure that the hypoglycemia protocol is complied with.

Under section 11. (1) (b) of O. Reg. 246/22, the licensee is required to comply with the plan, policy, protocol, procedure, strategy, or system that is required in the Act or Regulation. In accordance with O. Reg. 246/22 s. 123. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Rationale and Summary: Licensee's policy IX-NSG F-10.00 Medication Incidents and Adverse Drug Reactions and Hypoglycemia Protocol revised on October 2020, under medication incidents indicates that in the event of hypoglycemia <2.8mmol/L the resident should be assessed and immediate action to maintain the health of the resident should be taken and to be reported to the resident/SDM and physician and documented in the resident's chart. Also, under All Medication Incidents and Adverse Drug Reactions/Hypoglycemic Incident the registered staff needs to complete a hypoglycemic assessment in Point Click Care (PCC) for all hypoglycemic reactions below 4mmol/L.

A resident's health care record identified that on a specified day, their blood sugar level was low. The RPN confirmed that they did not complete the hypoglycemic assessment tool. On the next day, the resident's health record indicated that their blood sugar level was low, the Assistant Vice President of Nursing confirmed that the physician/SDM was not notified of the incident.

Sources: Licensee's policy on Medication Incidents and Adverse Drug Reactions and Hypoglycemia Protocol IX NSG F-10.00 dated October 2020. The resident's health care record, and interview with the Assistant Vice President of Nursing. [740864]

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 34 (1) 2.

The licensee has failed, under the program, to ensure that the resident was in a mobility device appropriate for the resident based on the resident's condition.

Rationale and Summary: Review of an resident's health care record identified that the resident sustained a fall incident, from a transport wheelchair. The RPN stated that the resident was left unattended in a transport wheelchair, and this was not appropriate for the resident.

Restorative Care Staff (RCS) stated in their interview that transport wheelchairs are not appropriate for use except for direct locomotion of residents. The RCS also stated that residents are not to be left in transport wheelchairs unattended. Failure to ensure that the resident was in an appropriate mobility device resulted in actual harm to the resident.

Sources: The resident's care plan, interviews with the Assistant Vice President of Nursing, the RPN, and the RCS. [740785]

WRITTEN NOTIFICATION: Safe transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that the PSW used safe transferring techniques while assisting the resident.

Rationale and Summary: Video footage reviewed by the inspector showed that, a PSW used inappropriate techniques to transfer and ambulate a resident. Vice-President of Nursing, in their interview, indicated that the PSW was not aware of the resident's transfer and ambulation status and did not use safe transfer and ambulation techniques appropriate to the resident's needs. Failure of the PSW to use appropriate transfer techniques for the resident put the resident at significant risk of harm.

Sources: Video footage of the resident, the resident's plan of care and interview with the Vice-President of Nursing. [740785]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 6.

The licensee has failed to ensure that the resident was given sufficient time to eat at their own pace.

Rationale and Summary: During this inspection, the inspector observed a resident was eating their lunch meal. An PSW, next to the resident was also assisting with the resident's feeding. The inspector observed that the PSW was feeding the resident with the main course and the dessert simultaneously. Furthermore, it was observed that the resident continued to eat their main course and simultaneously the PSW was feeding the dessert. The inspector observed the resident saying to the PSW "take your time". Review of the resident's plan of care identified that the resident was at moderate nutritional risk. The resident's plan of care identified the resident as a slow eater.

The inspector spoke with the PSW, who stated that they wanted to give the main course and dessert at the same time. Furthermore, they indicated that the dessert helps the resident to swallow their main course and stated, "it's already time". The inspector observed that the resident was not given sufficient time to eat at their own pace. The action of the PSW staff placed the resident at risk of reduced nutritional intake and decreased enjoyment of the meal.

Sources: Inspector observation, the resident's plan of care, interview with the PSW and other staff. [573]