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

Ottawa District
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Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: February 9, 2024

Inspection Number: 2024-1510-0001

Inspection Type:
Complaint
Critical Incident
Follow up

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

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

Lead Inspector	**Inspector Digital Signature**
Maryse Lapensee (000727)	Maryse C Lapensee Digitally signed by Maryse C Lapensee Date: 2024.02.09 14:48:17 -05'00'

Additional Inspector(s)
Marko Punzalan (742406)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30, 31, 2024 and February 1, 2, 5, 6, 2024

The following intake(s) were inspected:

- Intake: #00086237 / CI 3015-000034-23 - related to alleged physical and emotional abuse of resident by staff
- Intake: #00086459 / CI 3015-000035-23 - related to alleged sexual abuse of resident by agency staff
- Intake: #00089448 / CI 3015-000043-23 - related to alleged emotional abuse of resident by staff

- Intake: #00106292 / CI 3015-000002-24 - Fall of a resident resulting in a significant injury and change in condition
- Intake: #00106416 / CI 3015-000003-24 - related to physical abuse to resident by resident
- Intake: #00099944 - Complaint related to resident care
- Intake: #00106009 - Complaint related to bed alarm, and hourly rounding not being completed.
- Intake: #00101804 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b)

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1510-0008 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Marko Punzalan (742406)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to comply with FLTCA, 2021 s. 6 (7) related to ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary:
A resident had an incident of hitting a co-resident on a specific date in January 2024. The licensee reported that the identified resident continued to fixate on a specific co-resident. To address the risk the home ordered 1:1 companion as an intervention in the plan of care.

The written plan of care indicated that 1:1 supervision is present at all times and should be relieved by a PSW during the companion's breaks.

Inspector #74406 observed on February 05, 2024, for 35 minutes, no 1:1 companion was present with the resident.

Interview with a Registered Practical Nurse (RPN) confirmed the plan of care for the resident, the 1:1 companion should be relieved by staff when on break.

Interview with a Registered Nurse (RN) confirmed the plan of care for the resident indicated that registered staff should arrange the coverage of 1:1 companion when they take their breaks.

Interview with the Assistant Vice President of Nursing (AVPN) confirmed that registered staff are expected to arrange the coverage of the 1:1 companion when taking their breaks.

Failure to ensure that the care set out in the plan of care is provided to the resident as specified in the plan increases the risk of harm and safety to co-residents.

Sources: Resident's health care records, interview with RPN, RN and AVPN [742406]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary:
A resident's health care records indicated that behavioural monitoring was initiated in January 2024, for seven days to observe for possible responsive behaviours using the Dementia Observation Scale (DOS).

During the health care records review of the resident, there were two shifts identified where the resident's behaviour was not documented on specific dates in January 2024, during specific times.

Interview with a Registered Practical Nurse (RPN), they confirmed that staff should be documenting hourly observations of the resident's behaviours using a DOS monitoring tool.

During an interview, the Assistant Vice President of Nursing (AVPN) indicated that staff were expected to document the behavioural monitoring of the resident using a DOS monitoring tool for the identified timeframe.

As such, the provision of care set out in the resident's plan of care regarding monitoring of responsive behaviours was not documented.

Sources: Resident's health care records, and interview with RPN and AVPN. [742406]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
On a specific date in June 2023, a Critical Incident Report (CIR) was submitted in regards of an allegation of verbal abuse toward a resident by a Personal Support Worker (PSW) that occurred during a specific shift in June 2023.

A Registered Practical Nurse (RPN) confirmed that a co-resident reported to them, the following day of the incident, that a PSW yelled at a resident. The RPN acknowledged that their role is to report to the Registered Nurse (RN) or management when they suspect an allegation of abuse. The RPN confirmed that they did not notify the RN, but they sent an email to management to notify them of the reported allegation of abuse toward a resident by a PSW.

The Vice President of Nursing (VPN) stated that the expectation for allegations of abuse was supposed to be immediately reported to the supervisor. RPN would report to the RN or manager and if during the weekend, the manager on call. The VPN confirmed that the reporting process was not followed for the specific incident, related to the allegation of abuse and it was late reporting.

The risk of not reporting alleged abuse immediately to the Director is that it may delay investigation and follow up into reports of alleged abuse.

Sources: CIR, Interviews with RPN and VPN
[000727]