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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 27, 2024

Inspection Number: 2024-1510-0002

Inspection Type:
Complaint
Critical Incident

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

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

Lead Inspector	**Inspector Digital Signature**
Gurpreet Gill (705004)	Gurpreet K Gill Digitally signed by Gurpreet K Gill Date: 2024.04.26 15:00:22 -04'00'

Additional Inspector(s)
Kelly Boisclair-Buffam (000724)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 13, 14, 15, 18, 19, 2024

The following intake(s) were inspected:

- Intake: #00096893 [CI:3015-000071-23] related to - COVID-19 outbreak declared
- Intake: #00106670 [CI:3015-000005-24] related to written complaints to the home regarding resident's roommate
- Intake: #00108540 [CI: 3015-000009-24] related to an injury to a resident with an unknown cause
- Intake: #00109380 [CI:3015-000013-24] related to Parainfluenza outbreak declared

- Intake: #00108632: complaint related to care and services and resident's diet
- Intake: #00109550: complaint regarding alleged neglect leading to resident death
- Intake: #00111855: complaint regarding laundry services.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain 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 ensure that the care set out in the plan of care for a resident is provided to the resident as specified in the plan when the resident was not served their required texture.

Rationale and Summary

A review of the resident's health care records indicated that the resident was on a texture modified diet.

The food service supervisor indicated that the resident received regular textured mashed potatoes instead of their specific texture and had only a few bites. They further indicated that the dietary staff served the resident mashed potatoes instead of their specific texture.

As such there was a potential risk of choking to the resident as they were not served food of the correct texture.

Sources: A review of resident's clinical records and an interview with the food service supervisor. [705004]

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 care set out in the plan of care for fluid and nutritional intake were documented for a resident.

Rationale and Summary

The resident was admitted to the home in July 2022 with a medical condition requiring a specific diet and fluid consistency, and a specific medication.

A review of the resident's health care records, indicated that fluids were to be pushed, with an extra three glasses of fluid per day and an additional 125 milliliters (ml) of Resource 2.0, three times per day. The instructions also indicated that staff were to monitor the residents' urinary output every shift, any symptoms of dehydration, any side effects of the specific medication, and, to document all amounts of intake and output.

The Documentation Survey Report from the residents' electronic chart, showed multiple missed entries for fluid intake in the months of January, 2024 and February, 2024.

For the month of January 2024, there were 19 days, where resident's snack and fluid intake at 1400 hours, three days where supper and snack intake were not documented. In addition, there were 19 days in January 2024, where food and fluid intake at breakfast, lunch and 1000 hours fluids were not documented.

For the month of February 2024, there were 8 days, where snack and fluid intake at 1400 hours were not documented.

The resident was admitted to hospital on a specific day in February 2024 for health decline.

The Resident's progress notes from the Registered Dietitian for December 2023, showed a note had been made that only on occasion was the fluid intake documented in the electronic chart.

During Inspector #000724 interviews, a Personal Support Worker (PSW), the Registered Dietitian and the Assistant Vice President of Nursing (AVP Nursing) all stated that the expectation is that all PSWs' document the resident's nutritional and fluid intake every day and every shift as indicated in the Point of Care (POC).The AVP Nursing further acknowledged the missing documented entries.

As such, failing to ensure that all nutritional and hydration intakes were documented, may have placed the resident at risk for malnutrition and dehydration.

Sources: The resident's health care record and Interview with an identified staff member. [000724]

COMPLIANCE ORDER CO #001 Safe storage of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22 s. 139.1.
The licensee shall:
A) Perform at a minimum, one weekly audit on both day and evening shifts to ensure that registered nursing staff are locking the medication carts when unattended. The audits are to be completed until such time that the Ministry of

Long-Term Care has deemed that the licensee has complied with this order.
B) Take immediate corrective action to address staff non-compliance with locking the medication cart when unattended.
C) Perform weekly audits of medication carts to ensure that they are in good working order, thus preventing registered nursing staff from locking the medication cart.
D) Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that drugs stored in an area or a medication cart are secure and locked.

On a day in March 2024, Inspector observed that the medication cart in a specified home area was unlocked and noted that the narcotic drawer was not closed. There were no registered staff around the cart. The Inspector was able to open medication and narcotic drawers and have access to all the medications. A Registered Practical Nurse (RPN) was in the dining room administering medication to a resident. The medication cart was near the dining area while residents were seated in the dining room and a few were walking past the medication cart.

On the same day in March 2024, upon entering another specified home area, Inspector observed that an RPN was near the medication cart and preparing medication. The medication cart was near the nursing office and the dining area. After preparing the medication, the RPN did not lock the medication cart and proceeded to the dining room to administer the medication. After returning, they poured water for a resident and left without locking the medication cart. Subsequently, they returned to the cart, took a tray, and went to the dining room, leaving the medication cart unlocked.

On the morning of another day in March 2024, upon entering a specified home area, Inspector observed that the medication cart was in front of the medication room and was unlocked. The registered staff was not present. It was observed that an RPN and a student RPN were in the nursing office. It was observed that two residents were sitting near the medication room, while a few were in the dining room.

Three days later, upon entering a specified home area around 1200 hours, Inspector observed that an RPN was administering medication to a resident in the dining room. The medication cart was not locked. The residents were in the dining room and walking near the medication cart. The medication cart was near the dining room.

During an interview with the RPN, they indicated that they forgot to lock the medication cart. Another RPN indicated that they are supposed to lock the medication cart when they are not present.

During interviews with the RPN and student RPN, they indicated they are supposed to lock the medication cart when they are not present near the medication cart. Another RPN indicated they are supposed to lock the medication cart, but if they lock it, they cannot open it because the key and swipe card are not working. There has been an issue with the key and lock mechanism for a month.

The acting Director of Care (DOC) indicated that medication carts should be kept locked at all times when not attended. Furthermore, they also indicated that the RPN should have used the backup key to lock the medication cart.

Failure to ensure that the medication carts were locked when not in use increased the risk for residents to be able to access medications and cause potential harm.

Sources: Observations and interviews with the Acting DOC and four RPNs and a student RPN. [705004]

This order must be complied with by May 24, 2024

REVIEW/APPEAL INFORMATION

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;
(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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.