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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# Public Report

**Report Issue Date:** November 7, 2025

**Inspection Number:** 2025-1510-0006

**Inspection Type:**
Complaint
Critical Incident

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

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

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4, 5, 6, 7, 2025

The following intake(s) were inspected:

- Intake: #00153912 - Related to improper/incompetent care of a resident
- Intake: #00155502 - Complaint related to resident rights
- Intake: #00159823 - Complaint related to pureed food options
- Intake: #00160699 - Related to suspected neglect of a resident

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

Food, Nutrition and Hydration
Prevention of Abuse and Neglect

## 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 was provided as specified in the plan. Specifically, the resident's care plan specified the resident is to have a regular Personal Support Worker (PSW) assigned to them. On a specific date, the resident was not assigned a regular Personal Support Worker.

Sources: Resident health records, licensee's internal investigation notes, interviews with a Registered Practical Nurse and the Assistant Vice-President of Nursing.

## WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 24 (1)**
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from neglect on a specified date.

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety

or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

On a specific date, the resident activated their call bell and the call bell was not attended to for an extended period of time. The licensee's internal investigation determined that staff did not communicate with the resident to determine their care needs which resulted in the resident not receiving a meal or their personal care. In addition, the resident experienced significant stress and emotional distress.

Sources: Licensee's internal investigation notes, interview with the Vice-President of Nursing and the Assistant Vice-President of Nursing.