Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2014	2014_128138_0006	O-001223-13 O-000008-14	Complaint

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr., OTTAWA, ON, K1V-8N5

Long-Term Care Home/Foyer de soins de longue durée

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 10, 11, and 12, 2014

During the course of the inspection, the inspector(s) spoke with the President and CEO, Coordinator of Clinical Practice and Performance, RAI Coordinator, Manager of Support Services, Vice President Resident Care, Vice President Clinical Care, several personal support workers, a recreation aide, a registered nurse, several registered practical nurses, a food service worker, and residents.

During the course of the inspection, the inspector(s) obtained the home's policy on skin and wound care, reviewed resident health care records, observed resident care, observed a meal service, and observed a medication pass.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Medication
Personal Support Services
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.3. (1) 1. in that the licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Long Term Care Home Inspector #138 reviewed a resident's health record that outlined an incident a day in December 2013 in which a individual was upset and had reported to the unit registered practical nurse (RPN) that s/he had found a resident lying in bed with his/her pants down and no blankets covering the resident. The Inspector spoke with the unit RPN who wrote the progress note about the incident. The RPN stated to the Inspector that the individual did approach her when the incident occurred and was concerned that the resident had been exposed and visible by others. The RPN stated to the Inspector that the resident did have a continence product on at the time but that his/her pants were down and there were no blankets covering the resident.
The Inspector also spoke with a personal support worker (PSW) who had been on duty on the unit when the incident occurred. The PSW stated that it had been the practice of day staff to put residents back to bed in the afternoon and leave the residents' pants down as a way of making it easier for evening staff to check continence products when doing rounds. The PSW stated that this particular resident was assisted to bed for a nap with his/her continence product on but his/her pants down. The PSW further stated that she was unable to comment as to whether the resident was covered by a blanket.
Inspector spoke with the Vice President Clinical Care who stated that she had investigated the incident. The Vice President Clinical Care further stated that she spoke with the unit staff and was able to confirm that an incident occurred and that the home provided re-instruction to staff.

In addition, while on a unit in the home, the Inspector also observed a staff member transferring a resident from a wheelchair to the unit washroom adjacent to the unit dining room. It was observed by the Inspector that the resident's back side from the waist down was exposed and visible to visitors and residents in the dining room while the resident was being transferred to the washroom. Staff did not make any attempt to cover the resident up.

The home failed to respect both residents' dignity as both residents were exposed and visible to others. [s. 3. (1) 1.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6 (5) in that the licensee failed to ensure that the resident's substitute decision-maker is given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Long Term Care Home Inspector #138 spoke to a personal support worker (PSW) regarding bruising to residents' skin. The PSW stated that front line staff are to monitor residents' skin daily and report any bruising to the registered staff. The Inspector spoke to a registered practical nurse (RPN), a registered nurse (RN), the Vice President Clinical Care, and the Vice President Resident Care regarding the presence of bruising on residents' skin. All stated that the PSW's are to monitor residents' skin and report bruising to the registered staff. The registered staff will then enter a progress note about the bruising, complete an incident report, and then notify the substitute decision-maker about the bruising. All also stated that notification to the substitute decision-maker would be documented.
The Inspector reviewed a resident's health record for progress note entries related to bruising and, along with the RAI Coordinator, reviewed incident reports related to bruising. It was observed by the Inspector that there were several incidents related to residents' bruising in which there was no documentation that the substitute decision-maker was notified.
[s. 6. (5)]

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Issued on this 13th day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

PAULA MACDONALD