



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

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

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Performance Improvement and
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**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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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
Jun 5, 2014	2014_362138_0008	O-000359- 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



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

This inspection was conducted on the following date(s): June 3 and 4, 2014

A monitoring visit for outstanding Orders was conducted on June 3, 2014 and Compliant Inspection O-000359-14 was conducted on June 4, 2014.

During the course of the inspection, the inspector(s) spoke with the Manager of Support Services, Vice President Resident Care, Nutritional Supervisor, Chief Executive Officer (CEO), several Registered Practical Nurses (RPNs), several Registered Nurses (RNs), several Personal Support Workers (PSWs), a Recreologist, several Nutritional Service Aides, a Laundry Aide, a private care giver, and several residents.

During the course of the inspection, the inspector(s) observed several meals services, observed morning care routines, toured a unit during the night shift, audited several residents' closets and drawers to verify labeling of resident clothing and to verify that residents have the correct clothing, determined the resident clothing labeling program, determined the home's process for reported resident lost items, and reviewed several residents' health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Dining Observation

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :



The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, section 8 (1)(b) in that the licensee failed to ensure that there is an organized program of personal support services for the home to meet the morning needs of the residents on Waterford House.

LTCH Inspector #138 was on a unit the morning of June 3, 2014 to observe the breakfast meal service and morning care related to an outstanding order (CO #001, Inspection # 2014_198117_0011) that was issued on May 9, 2014. It was noted by the inspector that not all residents were in the dining room prior to the end of the scheduled meal service at 9:30am. It was also observed by the inspector that the Recreologist who is scheduled to assist in the dining room from 8:00 am until 8:45 am left the dining room at 9:05 am. The PSW who was scheduled to be present in the dining room at 8:45 am was not present until 9:20 am, leaving a fifteen minute widow when only a volunteer was assisting residents in the dining rom. Several residents were observed to require assistance during this time and it was observed that the residents did not receive the assistance required. Several residents were observed not eating and no assistance or encouragement was provided.

In addition, the LTCH Inspector #138 did not observe that, in accordance with O.Reg 79/10 s. 71 (3) (b), each resident was offered a minimum of a between-meal beverage in the morning on June 3, 2014. The inspector spoke with a PSW who stated that morning fluids are not offered to all residents but that there are plans to start such a program.

Note that a Compliance Order #001 for LTCHA 2007, S.O. 2007, c.8, s. 31 was issued on May 9, 2014, Inspection # 2014_198117_0011. Full compliance for this Compliance Order is due on July 1, 2014. Therefore, the above evidence is additional information for Compliance Order #001 [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices



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Specifically failed to comply with the following:

**s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).**

Findings/Faits saillants :



The licensee failed to comply with LTCHA 2007, S.O 2007, c.8, s. 31 (3) (c) in that residents who are being restrained are not released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations.

In accordance with O. Reg 79/10 s. 110. 2. which states that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: (4) every resident is to be released from the physical device and repositioned at least every two hours.

LTCH Inspector #138 was on a unit the morning of June 3, 2014 to observe the breakfast meal service and the morning care routine. It was noted by the inspector on arrival to the unit at 8:50 am that Resident #1 was in the lounge in a wheelchair with a lap belt. Staff reported that the resident had eaten and was removed from the dining room. The inspector continued to observe the meal service as well as Resident #1 who was nearby. At 9:47 am, Resident #5 was observed to be transferred to the lounge in a wheelchair and wearing a lap belt. At 10:05 am, the inspector observed that there were several residents, including Resident #2, Resident #3, Resident #4, and Resident #5 watching TV, seated in their wheelchairs each wearing a lap belt. The inspector observed the five residents throughout the course of the morning until leaving the unit at 12:50 pm. It was observed by the inspector that all five of the residents had not been released from their lap belts and repositioned during the time observed by the inspector which was in excess of at least two and a half hours for each resident.

LTCH Inspector #138 reviewed the plans of care for the five residents noted above and it was noted that Resident # 1, Resident #4, and Resident #5 are care planned to use restraints. LTCH Inspector #138 spoke with a unit PSW who stated that Resident #2 and Resident #3 wore lap belts but that these two residents are not able to release the lap belt. This, by definition, makes the lap belt for these two residents a restraint.

Note that a Compliance Order #002 for LTCHA 2007, S.O. 2007, c.8, s. 31 was issued on May 9, 2014, Inspection # 2014_198117_0011. Full compliance for this Compliance Order is due on July 1, 2014. Therefore, the above evidence is additional information for Compliance Order #002. [s. 31. (3) (c)]



WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110.

Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 110. (1) 1. in that the licensee of the long term care home failed to ensure that the following requirements are met with respect to the the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. staff apply the physical device in accordance with any manufacture's directions.

LTCH Inspector #138 was on a unit on June 3, 2014 and observed that Resident #1 was in a wheelchair with a lap belt applied. The inspector further reviewed the lap belt and noted that it could be pulled away from the body approximately six to eight inches. The inspector discussed the lap belt for Resident #1 with the unit RPN who stated that the lap belt was too loose and then proceeded to adjust the lap belt.

LTCH Inspector #138 reviewed Resident #1's plan of care that outlined that the resident uses a lap belt as a restraint.

Note that a Compliance Order #002 for LTCHA 2007, S.O. 2007, c.8, s. 31 was issued on May 9, 2014, Inspection # 2014_198117_0011. Full compliance for this Compliance Order is due on July 1, 2014. Therefore, the above evidence is additional information for Compliance Order #002. [s. 110. (1) 1.]



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Issued on this 5th day of June, 2014

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