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**

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 16, 2015 | 2015_198117_0002 | O-000405-14 & O-001482-15 | 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

LYNE DUCHESNE (117)

### 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): January 13,14 and 16, 2015**

**It is noted that the two complaint inspections were conducted concurrently during this inspection.**

**During the course of the inspection, the inspector(s) spoke with Vice-President Nursing Practice, Vice-President of Clinical Care, the Clinical Care Coordinator, an attending physician, a Registered Nurse (RN), several Registered Practical Nurses (RPNs) several Personal Support Workers (PSWs), Restorative Care lead, activity aide, housekeeping aide and to several residents. The inspector also reviewed several identified resident's health care records, plans of care, policies and other documentation within the home.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Nutrition and Hydration**
**Personal Support Services**
**Reporting and Complaints**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the provision of the care set out in the plan of care is

documented. [Log # O-001482-14]

Resident #2 is has recurring skin rashes to the perineum and epiphora (watery eyes). The attending physician assessed the resident and prescribed the following the medicated creams and treatments.
For the resident's perineum skin rashes:
- on a specific day in November 2014: an antifungal cream to the perineum BID x 14 days.
- on a specific day in November 2014: an oral moisture spray QID and prn
- on a specific day in December 2014: a topical skin emolient cream BID and after pad change
- on a specific day in January 2015: an antifungal cream BID

For the resident's eyes:
- on a specific day in December 2014: warm compresses to the eyes each evening.
- 21 days later in December 2014: to cleanse the eyes with baby shampoo each evening.

A review of the resident's Treatment Administration Record (TAR) was done for the months of November 2014, December 2014 and January 2015. In November 2014, the administration of the prescribed antifungal cream was documented 8/28 times and in December 2014 it was also documented 8/28 times. There was no documentation in the TAR of the application of the antifungal cream in January 2015, as well as no documentation of the application of the oral moisture spray, topical skin emolient cream, warm compresses to the eye as per medical orders. The cleaning of Resident #2's eyes with baby shampoo was noted to have been done 2/15 times in December 2014/January 2015.

On January 13, 2015, unit RPN S#101 reported to Inspector #117 that the prescribed medicated creams are being applied as per medical orders and that compresses to the resident's eyes are done by evening PSW staff and/or Resident #2's private sitter, when the sitter is present at the home. Further review of the resident's health care record showed that some progress note documentation did indicate that the prescribed medicated creams are being applied and that the effectiveness of the treatment is being documented. On January 14, 2015, unit RN S#102 and the home's Clinical Care Coordinator stated to Inspector #117 that all medicated cream treatments and prescribed treatments such as the warm eye compresses, are to be documented in the resident TAR as per the home's policy #NSG12.00 on "Documentation on Treatment Record", revised on April 12, 2013.

Nursing staff did not document the administration of Resident #2's prescribed medicated creams and treatments. [s. 6. (9) 1.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the provision of care, especially the administration of prescribed medicated creams and treatments identified in the plan of care for Resident #2, is documented, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan be implemented. [Log# O-001482-14]

Resident #2 has advanced dementia and is incontinent of bladder and bowel. Resident #2 is on a bowel management plan in which the resident is monitored and if required will receive bowel management interventions. These interventions include the administration of an oral laxative medication, suppositories and enemas on an as needed basis. On January 13, 2015, unit RPN S#101 stated there was an additional directive related to the administration of fleet enemas. As per the RPN, nursing staff are to contact and notify Resident #2's POA to advise and seek consent prior to the administration of an enema when nursing staff identify the need for this bowel management intervention.

A review of Resident #2's health care record was conducted by Inspector #117. It was noted that the resident was administered enemas for constipation on a specified day in October 2014 and on a specified day in January 2015. There was no information in the progress notes or elsewhere to indicate that Resident #2's POA was contacted and gave consent for the administration of the enemas. Further review identified that there were no directives documented in the resident's chart to indicate that the resident's POA was to be contacted and consent sought prior to the administration of an enema as a bowel management intervention. The RPN S#101 confirmed to Inspector #117 that Resident #2's POA's request to be contacted for consent prior to the administration of enema interventions was not documented in the resident's chart or Medication Administration Records. A posted note in the unit medication room with this directive was the only source of information regarding this directive. Resident #2's plan of care for bowel management interventions was not individualized to clearly reflect directives to advise and seek the POA's consent prior to the administration of enemas.

During the review, it was noted that Resident #2's plan of care identifies that the resident is on a scheduled toileting plan and wears continence briefs. The plan also identifies that the resident is continent of bowels and requires 2 staff assistance to toilet with the use of a SARA lift. However the plan also indicates that the resident is a 2 person transfer assist with a full mechanical lift.

A discussion was held on January 14, 2015, with unit PSW staff S#103 and S#104 in regards to the Resident#2's toileting needs. Both PSWs report that the resident used to be continent of bowels and that the resident was toileted at least once per shift on the toilet with the aid of a SARA lift. Both staff members report that this has not occurred since August 2015, when the resident's health deteriorated. At that time the resident was fully incontinent of bladder and bowel and was assessed to require a full mechanical lift for all transfers; since then the resident has not been toileted on the toilet. The staff members S#103 and S#104 stated that the resident is usually toileted 3 times per shift (before breakfast, before lunch and once during afternoon) but there is no fixed schedule for this as identified in the plan of care.

On January 14, 2015, a discussion was held with the home's Clinical Care Coordinator. He stated to Inspector #117 that the resident's toileting plan of care should have been reviewed and individualized when there was a change in Resident #2's continence and transfer modes to reflect the resident's new toileting needs. [s. 51. (2) (b)]

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**Issued on this 16th day of January, 2015**

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

**Original report signed by the inspector.**