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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2017	2017_548592_0025	023885-17, 025570-17	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

MELANIE SARRAZIN (592)

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): November 10, 14, 15, 16, 17 and 21, 2017

One complaint was inspected regarding the reporting of alleged emotional/verbal abuse from a resident to co-residents (Log #025570-17)
One Critical incident was also inspected CI # C569-000055-17, Log #023885-17 regarding the reporting of alleged physical abuse involving the same resident referred in Log #025570-17 above.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Vice President Building Operator, one Schedule Clerk, one Recrealogist, one Charge Nurse, Registered Nursing Staff (RN/RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work routines, observed resident rooms, resident common areas, delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when
(b) the resident care needs change or care set out in the plan of care is no longer necessary;

An inspection was conducted following a complaint reporting alleged emotional/verbal abuse from resident #001 towards resident #002 and co-residents. The complaint was also about resident #001 wandering into co-residents rooms.

Inspector #592 reviewed resident #001's health care records.

The health care records indicated that resident #001 was admitted in 2017 with several diagnosis including cognitive impairment.

The progress notes for resident #001 indicated that within 24 hours of being admitted, resident #001 was observed with several behaviours such as wandering into other co-resident's room, being resistive to care, being verbally and physically abusive towards residents and staff members. Inspector #592 noted that there was documentation that resident #001 was still exhibiting behaviours which were not easily altered.

On November 21, 2017, resident #004 was identified by RN #110 to be fearful of resident #001. RN #110 indicated that resident #004 had expressed several weeks ago, concerns of being scared of resident #001 and was observed several times by RN #110 being shaky when resident #001 was wandering around him/her. RN #110 further indicated that resident #004 resides near resident #001's room and that resident #001 will often wander at the entrance of resident #004's room. She further indicated to the Inspector that there was no incident of physical altercation reported between the two residents, however, whenever resident #001 would yell in the dining room, resident #004 would get stressed and scared. RN #110 further indicated that resident #004 would often call his/her relative to report that resident #001 was wandering near his/her door and that the staff kept reassuring him/her, however, resident #004 was still expressing fear and stress as resident #001 will often roam in his/her room. RN #110 further indicated that the wandering episodes for resident #001 were not easily altered resulting in resident #004 having increased level of anxiety. RN #110 indicated that she was not aware of any new interventions done for resident #004 since he/she voiced his/her concerns about resident #001 other than continuing to reassure the resident.

On November 21, 2017, in an interview with resident #004, the resident indicated to the inspector that he/she was scared of resident #001. She further indicated that resident #001 would come in the entrance of the room at any time of the day and would go to the roommate's side of the room. She further indicated that resident #001 was "very bad" for his/her health and that the resident was not "finished" wandering. Resident #004 indicated that he/she was stressed and scared whenever he/she sees resident #001 around and Inspector observed that the resident was getting tearful and upset during the conversation.

A review of resident #002 progress notes was done by Inspector #592.

On a specific day in October 2017 the progress notes indicated that a phone call was received from the Substitute Decision Maker (SDM), of resident #004 which expressed serious concerns to the registered staff member about his/her relative having panic attacks when co-resident #001 enters his/her room and that his/her relative was scared. The progress notes further indicated that the SDM reported that he/she was contacted on a daily basis by his/her relative who was expressing fears and that he/she was worried about his/her relative's health. The notes further indicated that the SDM requested to speak to the nursing managers which he/she was re-directed to by the registered staff member and that reassurance was provided.

On a specific date in November 2017, the progress notes indicated that resident #004 had rang the bell and told the registered staff that he/she saw resident #001 going into his/her co-resident's room. The progress notes further indicated that resident #004 told the staff that resident #001 did not touch him/her as he/she was hiding in his/her room. The progress notes further indicated that the ADOC and the DOC were made aware.

Inspector #592 reviewed the current written plan of care for resident #004. The written plan of care indicated that resident #004 was identified with anxiety related to chronic discomfort, being cold or when irritated by co-residents and that interventions put in place were last reviewed 12 months ago.
The interventions put in place for resident #004 at that time were to:

-Encourage interaction with co-residents
-Encourage resident to attend activities on and off the unit
-Give an identified medication three times a day and before bathing
-Monitor resident for anxious behaviour, provide reassurance and assistance as needed.

-Resident is very sensitive to cold temperature and noise, gets easily irritated with co-residents.
-Resident anxiety increase due to language barrier or when in discomfort.

On November 21, 2017, in an interview with the Administrator, she indicated to the Inspector that she was contacted by resident's #004's SDM on a specific date in October 2017.She further indicated that the SDM has verbalized that his/her relative was anxious whenever she was seeing resident #001 go in the entrance of his/her room resulting of his/her relative calling whenever resident #001 was near the room. The Administrator further indicated that the SDM has mentioned that there has been no physical interaction between resident #001 and his/her relative, however his/her relative was fearful that resident #001 would seriously hurt him/her. The Administrator further indicated that the SDM was trying to find a way with the home to reduce his/her relative's fears. She further indicated that following the phone call from the SDM, she has updated the nursing team on how to best address resident #004 fears and how to reassure resident #004 to reduce his/her level of anxiety. The Administrator further indicated that measures were already in place for resident #004 due to underlying cause of anxiety since his/her admission and that she was unaware what other type of interventions or approaches were added in the resident's plan of care following the discussion with the team and the SDM.

Inspector #592 noted that resident #004 plan of care was last reviewed 12 months ago. No other new interventions or approaches were documented to respond to resident #004 fears and anxiety towards resident #001. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, specifically for resident #004 who has express fear and increase anxiety, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident demonstrating responsive behaviours, that;
(b) strategies are developed and implemented to respond to his behaviors. (log #023885 -17)

The licensee submitted a Critical Incident Report to the Director under LTCHA on a specific date in 2017, for an incident involving resident #001 and resident #003 for an alleged physical abuse.

Inspector #592 reviewed resident #001's health care records.

The progress notes for resident #001 indicated that on the day of the incident, at a specific time, resident #001 was witnessed in a specific area by staff members to be hitting co-resident #003 twice to a specific body part resulting in an injury. Resident #001 was removed from the area and medications were administrated.

A review of resident #001's health care records indicated that resident #001 was admitted on a specific date in 2017 with several diagnosis including cognitive impairment.

The progress notes for resident #001 indicated that within 24 hours of being admitted, resident #001 was observed with several behaviours such as wandering into other co-resident's room, being resistive to care, being verbally and physically abusive towards residents and staff members.

The progress notes further indicated that the home’s action taken at that time was to provide one on one monitoring of the resident which was started several days after the resident's admission to the home, during specific time of the day. The progress notes further indicated that resident #001's medications were reviewed by the physician and that the plan of care was adjusted with specific interventions made with the (BSO) and the Geriatric Psychiatric Outreach Team. The use of a behaviour mapping tool was also observed in the resident’s health care records which was initiated by the registered staff on the day of the admission. The progress notes further indicated that it was established that the resident’s behavior was more present during a specific time of the day, therefore one on one was required to be provided specifically on these specific time of the day, which was ended several weeks after the incident, after a re-assessment done from the DOC and the Charge Nurse.

Upon a review of the progress notes on the day of the incident, it was noted by Inspector #592 that there was no "one on one" provided at the time of the incident.

On November 14, 2017 in an interview with the DOC, she indicated to Inspector #592 that the home usually uses an agency when it comes for providing "one on one" to a resident. She indicated to the Inspector that when the home requires "one on one", the home will book the one on one for the next two weeks and the DOC will reassess every two weeks with the assistance of the charge nurse if the "one on one" still requires to be provided by reviewing incidents and assessments. She further indicated that the "one on one" was one of the strategies implemented for resident #001 to help the staff to respond to his/her several responsive behaviors and that "one on one" was adjusted as per resident #001's mood and needs until there was no more need, due to a decrease in behaviors and incidents. The DOC further indicated that the "one on one" was mostly provided to resident #001 on specific hours of the day due to increased behaviors at that time. She further indicated that five days prior to the incident, the home had decided to decrease the "one on one" hours by removing 60 minutes (one hour less of "one on one"), therefore the agency (sitter) was scheduled to come one hour later than the regular time. The DOC indicated that on the day before the incident, in a discussion with the nursing staff members, it was decided that resident #001 would have the "one on one" schedule back to the regular hours due to increased behaviors and that the "one on one" would be reassessed eight days later. The DOC indicated that on the day of the incident resident #001 was to have "one on one" provided but due to an error in the scheduling, there was no "one on one" provided at the time of the incident. The DOC further indicated that when the home is unable to have "one on one" present, the scheduling

person would tell the RN in order to have her focus more on the resident.

On November 14, 2017, in an interview with RN #102, RPN # 107 and PSW #108, who were working on the day of the incident, indicated to the Inspector that there were not aware that "one on one" was to be provided to resident #001 at the time of the incident. They further indicated that they were under the impression that the "one on one" was only to be provided one hour later on that day, therefore no one on one was provided as per the home's strategies to respond to resident #001 behaviours. [s. 53. (4) (b)]

2. The licensee has failed to ensure that each resident demonstrating responsive behaviours, that;
(c) actions are taken to respond to the need of residents, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

A complaint was received reporting alleged emotional/verbal abuse from resident #001 towards resident #002 and co-residents. (Log #025570-17)

Inspector #592 reviewed resident #001's health care records.

The health care records indicated that resident #001 was admitted in 2017 with several diagnosis including cognitive impairment.

The progress notes for resident #001 indicated that within 24 hours of being admitted, resident #001 was observed with several behaviours such as wandering into other co-resident's room, being resistive to care, being verbally and physically abusive towards residents and staff members.

The progress notes further indicated that the home's action taken was to provide "one on one" monitoring of the resident which was started several days after being admitted to the home, during specific time of the day. The progress notes further indicated that resident #001 medications were reviewed by the physician and that the plan of care was adjusted with specific interventions made with the (BSO) and the Geriatric Psychiatric Outreach Team. The use of a behaviour mapping tool was also observed in the resident's health care records which was initiated by the registered staff. The progress notes further indicated that it was established that the resident's behaviours were more present during the evenings, therefore "one on one" was required to be provided specifically on specific hours during the evenings which ended on a specific day after a

re-assessment done from the DOC and the Charge Nurse.

Inspector #592 noted in resident #001's progress notes that there was documentation about resident #001 still exhibiting behaviours which were not easily altered.

On November 10, 2017 at 11:10 hours, in an interview with full time PSW #101, she indicated to Inspector #592 that resident #001 was unpredictable as the resident could be quiet and then have sudden outbursts and was roaming in other co-residents rooms. PSW #101 indicated that there were no specific times, patterns or specific residents target of these behaviors. The staff needed to redirect the resident and monitor him/her closely which was done by all the staff members from different departments. She further indicated that behaviour mapping was presently being done for resident #001 as part of one of the actions taken in order for the physician to review resident #001's behaviours and adjust the medications on a weekly basis. When PSW #101 attempted to show the behaviour mapping form implemented for resident #001, the behaviour mapping form was not found. Several minutes later, PSW #101 showed to the Inspector a behaviour mapping form which was dated from the previous days ago. PSW #101 indicated that she was unable to find a current behaviour mapping form documentation. PSW #101 further indicated to the Inspector that she would need to initiate another form as it was recommended to have the behaviour mapping tool in place for resident #001. Inspector #592 observed several empty squares where there was no documentation entered for specific periods of time. PSW #101 indicated to the Inspector that the staff should document each hour resident #001's whereabouts and mood as per the home's expectations.

Inspector #592 noted the behaviour mapping tool in the resident's health care records, which was initiated since the resident's admission on an ongoing basis as part of one of the actions implemented by the home to reassess the residents mood and behaviours. Upon a review of the behaviour mapping tool, it was noted that there was no behaviour mapping tool documentation available for 11 days.

Inspector #592 also noted, that on a total of 63 days of behavior mapping, there were 50 times when no documentation was recorded for specific period of times.

On November 10, 2017, in an interview with the DOC and the Charge Nurse #100, they both indicated that resident #001 was on a behaviour monitoring mapping tool every hour since the day of his/her admission as part of the actions taken to respond to resident #001's behaviour. The Charge Nurse #100 further indicated that the behaviour mapping

tool should have been completed and that staff have received in the past some education on how to document on the behaviour monitoring mapping tool as well as the monitoring of the resident's behaviours every hour. The DOC and the Charge Nurse indicated that they realized that an intervention was put in place as part of actions taken to respond to the need of resident #001 but that staff did not use the mapping tool on a regular basis. The DOC and the Charge nurse indicated that they would do a follow-up immediately with the nursing team members to ensure that the monitoring of resident #001 was done and documented as part of the resident's needs. [s. 53. (4) (c)]

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 for each resident demonstrating, specifically resident #001 that strategies are developed and implemented to respond to these behaviours and that actions are taken to respond to the needs of resident #001, including assessments, reassessments and that the resident's response to interventions are documented, to be implemented voluntarily.

Issued on this 27th day of December, 2017

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

Original report signed by the inspector.