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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2018	2018_625133_0023	016497-18	Follow up

Licensee/Titulaire de permis

St. Patrick's Home of Ottawa Inc.
2865 Riverside Drive 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

JESSICA LAPENSEE (133), JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 5, 10, 12, 17, 2018

This inspection was in follow up to a compliance order issued as a result of Resident Quality Inspection #2018_617148_0016, related to the licensee's duty to protect residents from abuse. The compliance order was complied as a result of this inspection.

During the course of the inspection, the inspector(s) spoke with The President & Chief Executive Officer, the Vice President of Nursing, the Assistant Vice President of Nursing, registered and non-registered nursing staff, a physiotherapy assistant, a resident's Physician and residents.

During the course of the inspection, the inspector(s) observed identified residents and reviewed identified residents' health care records.

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2018_617148_0016	133

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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of the care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

On October 5, 2018, in an identified area of a specified care unit, the Inspector greeted resident #002 and the resident asked the inspector to take them to a bedroom, using a gender pronoun to specify the bedroom that they wanted to be taken to. Resident #002 was seated in their identified mobility device. Personal Support Worker (PSW) #110 redirected the resident and the resident agreed to remain in the area. The Inspector left the area and returned to speak with PSW #110 ten minutes later, however, PSW #110 had left for the day. The Inspector informed PSW#101, who was also the Behavior Support Ontario (BSO) worker, about resident #002's request. PSW/BSO #101 approached resident #002 and the resident asked PSW/BSO #101 to take them to see a person with an identified relationship to the resident (the person), using the name of the deceased person. Registered Practical Nurse (RPN) #111 indicated to the resident that the person had gone for the day and the resident was agreeable to this explanation. PSW/BSO #101 indicated to the Inspector that they were surprised by resident #002's request, as the resident had not recently asked for the person. PSW/BSO #101 indicated that in the past, resident #002 had recognized a co-resident, resident #001, as the person, and resident #002 would seek out and initiate affection towards resident #001, which resident #001 would reciprocate. PSW/BSO #101 indicated that resident #002 was ambulating independently at that time, which had changed in an identified month in 2018 when resident #002 sustained an injury and consequently required use of the identified mobility device. PSW/BSO #101 indicated that there used to be a plan of care in place, for resident #001 and #002, related to these behaviors. PSW/BSO #101

indicated that these behaviors were no longer occurring, and therefore the related components of the plans of care had been resolved.

On October 10, 2018, resident #001 indicated to the Inspector that they believed that resident #002 had affection for them. Resident #001 then qualified that "we don't see each other anymore".

On October 10, 2018, PSW #105, PSW/BSO #110 and RPN #102 indicated that they were not aware of any recent interactions between resident #001 and resident #002.

On October 10, 2018, the Vice President of Nursing (VPN) #103 and the Assistant Vice President of Nursing (AVPN) #104 were interviewed. Resident #002's diagnosis of dementia, and resident #002's Cognitive Performance Score, were noted. Related to resident #002's plan of care, VPN #103 indicated that a focus related to the behavior problem of thinking resident #001 was the deceased person and initiating affection towards resident #001 had been resolved on an identified date in 2018. VPN #103 indicated that a focus related to wandering, with intervention to keep resident #002 under staff supervision at all times as resident #002 wandered to resident #001 thinking resident #001 was the deceased person, was resolved on the same identified date in 2018. VPN #103 indicated that the behavior problem had not occurred since resident #002 had returned from the hospital on an identified date in 2018, after they had sustained an injury. AVPN #103 indicated the focus related to resident #002's behavior problem was resolved from the plan of care following a chart review and discussion with staff, which led to their understanding that resident #001 and resident #002 no longer had interest in each other. VPN #103 indicated that the focus related to wandering was resolved as resident #002 had not been ambulating independently since resident #002 had returned from the hospital on an identified date in 2018.

Two identified 2018 minimum data set (MDS) assessments for resident #002, indicated that the resident had memory problems and was unable to make decisions. As per the two MDS assessments, wandering behavior and socially inappropriate or disruptive behavioral symptoms, which includes sexual behavior, had not occurred in the last seven days of the assessment period. On October 10, 2018, VPN #103 indicated that the MDS assessments were populated by the point of care documentation that is completed by personal support workers (PSWs) on all shift, confirmed by the Registered Practical Nurses (RPN) and coded by the RPNs or the RAI Coordinators.

On October 12, 2018, PSW #107 indicated that they no longer saw interactions between

resident #001 and #002. PSW #107 indicated that resident #002 will regularly ask where the person is, at times using the name of the deceased person. PSW #107 indicated that resident #002 continued to recognize resident #001 as the person, and would make reference to resident #001 using the name of the deceased person. PSW #107 indicated that, for example, they will bring resident #002 to their table in the dining room and resident #002 will recognize resident #001 and say that resident #001 is the person. PSW #107 indicated that resident #001 does not respond in such cases. PSW #107 indicated that they had never documented about this in point of care as there had never been an incident of contact between resident #002 and resident #001, and resident #002 was easily redirected. PSW #107 indicated that resident #002's mobility was starting to change. PSW #107 indicated that resident #002 was starting to use a different identified mobility device, qualifying that this occurred only with assistance from staff. PSW #107 described the assistance required and resident #002's continuing mobility challenges.

On October 12, 2018, resident #002's plan of care was reviewed by the Inspector and it was noted that it did not reflect that resident #002 continued to identify resident #001 as the person. The Inspector notified VPN #103, who indicated that they had not been aware that this aspect of resident #002's past behavior problem continued.

On October 12, 2018, resident #002's plan of care was updated to include a focus for behavior problem related to dementia exampled by resident #002 thinking resident #001 was the person. The updated plan of care included an intervention that specified that resident #002 was always searching for the person, caregivers to monitor closely, and keep resident #002 distant from resident #001.

On October 15, 2018, the Inspector observed resident #002 in an identified area of a specified care unit with the different identified mobility device in their immediate proximity. Physiotherapy Assistant (PA) #108 indicated that they had just assisted resident #002 to mobilize, with the mobility device. PA #108 described two current challenges to resident #002's mobility. PA #108 indicated they were focused on specified exercises for resident #002, with a goal for resident #002 to regain independent mobility. Related to resident #001, PA#108 indicated that two or three times in the last month, in exercise class, resident #002 thought resident #001 was the person. PA #108 indicated that resident #002 would say "look, there is [the person]!" and then greet resident #001 with a term of endearment. PA #108 indicated they would explain to resident #002 that resident #001 was not the person and resident #002 would accept that. PA#108 indicated that resident #001 would not respond, and PA #108 would change the topic and begin the exercise class. PA #108 indicated that in exercise class, there

resident #001 and resident #002 separated, due to past behavior issues.

The licensee has failed to ensure that the staff and others involved in the different aspects of the care of resident #002 collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [s. 6. (4)]

Issued on this 7th day of November, 2018

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

Original report signed by the inspector.