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
Feb 12, 2019	2019_617148_0002	012025-18, 014863-18, 017160-18, 023316-18, 025668-18, 026841-18, 028501-18, 028991-18	Critical Incident System

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 11, 14-17, 21, 25 and 28, 2019

This inspection included the following logs: 012025-18 (C569-000047-18), 014863-18 (C569-000048-18) and 023316-18 (C569-000056-18) related to resident to resident alleged physical abuse that resulted in harm or risk of harm to the resident; 017160 -18 (C569-000050-18), 025668-18 (C569-000057-18), 026841-18 (C569-000059-18), 028501-18 (C569-000060-18) related to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status; and 028991-18 (C569-000064-18), related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the home's President and Chief Executive Officer, Vice President of Nursing, Assistant Vice President of Nursing, Admission Clerk, Resident Assessment Instrument- Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), family members and residents.

In addition, the Inspector reviewed identified resident health care records and documents related to the home's investigations into the identified critical incident reports. The Inspector observed resident care environments, resident care, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours

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

- **1 WN(s)**
- **1 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	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #003 was identified as being at high risk of falls and was known to attempt to self transfer unsafely. The resident was described by the plan of care and PSW staff to have responsive behaviours that were exhibited by restlessness and agitation which furthered the resident's risk of falls.

On a specified date, resident #003 attempted to self transfer resulting in an unwitnessed fall and injury. In discussion with PSW #110 who was on the unit at the time of the incident, the PSW described that the resident was agitated; the agitation was increased when the resident was left alone. PSW #110 indicated that the resident was provided with intermittent supervision during this time. The PSW recalls speaking to resident #003 and cuing the resident to stay seated, however, upon the PSW's return to the resident, the resident was found on the floor.

A review of the health care record including the plan of care and consent for restraint, indicated that the resident had available for use a physical device as a restraint for safety and fall risk, as needed, to prevent self transfer when anxious or restless. In review of the two most recent MDS Assessments completed prior to the date of the fall, the use of the physical device was not identified. The Inspector spoke with RPN #112, PSW #110 and PSW #111 who described the resident as regularly becoming agitated. It was indicated

by the staff members that the resident could continue to self transfer when agitated, despite having the physical device applied.

PSW #111 reported that the physical device was used when the resident was agitated and when staff were not able to provide constant supervision. PSW #111 noted that the resident was not always accepting of the application of the physical device. It was described by both PSW #111 and RPN #113 that the physical device may increase behaviours rather than assist to calm the resident. PSW #110 reported that the physical device did not assist with the safety of the resident as the resident would continue to self transfer.

It was identified during staff interviews with the RAI-MDS Coordinator and three PSW staff members, that resident #003 had a second physical device available for use to assist in preventing self transfer. PSW #110 indicated that at the last observation of the resident prior to the fall, the resident had released this physical device. In review of the most recent MDS assessment the physical device was coded as in use. The plan of care at the time of the fall did not include the use of the second physical device.

Interviews with staff and the health care record did not demonstrate that the fall risk and responsive behavior interventions were based on an assessment of the resident or the needs and preferences of the resident. [s. 6. (2)]

2. Resident #001 has a diagnosis of dementia and has exhibited various responsive behaviours. On a specified date, the resident had a fall resulting in an injury and change in health status, whereby the resident no longer ambulates and is dependent on staff to mobilize.

The current plan of care for resident #001, related the responsive behaviours indicated that the resident was known to make actions and gestures of a sexual nature toward other residents, can be resistive to care and aggressive towards other residents.

The Inspector spoke with three PSW staff and the regular RPN that provided direct care to this resident. Each of the staff described current responsive behaviours to include yelling out and being resistive to care, whereby the resident may become physically aggressive with staff. Staff described that due to the change in mobility, resident #001 no longer exhibits physical aggression towards other residents. Staff reported that behaviours exhibited no longer included actions or gestures of a sexual nature towards other residents.

The plan of care for resident #001, related to responsive behavious, was not based on the resident's current needs. [s. 6. (2)]

3. The licensee has failed to ensure that the effectiveness of the plan of care is documented.

Resident #003 was identified as being at high risk of falls with responsive behaviours that contributed to that risk. The resident had a physician order for an antidepressant as needed and an order for an antipsychotic to be given as second choice if the antidepressant was ineffective with one hour.

A progress note at a specified time of day, written by RPN #113, indicated that resident #003 was administered the antidepressant for increased agitation and for staff to monitor. Two hours later, resident #003 was found on the floor having fallen resulting in an injury. PSW #110 who observed the resident prior to the fall, described that the resident was demonstrating agitation. In review of the electronic medication administration record, medication notes and progress notes, the effectiveness of the antidepressant had not been documented and no antispychotic had not been administered.

The Inspector spoke with RPN #113 who could not recall the administration of medications on the specified date nor the effectiveness of the antidepressant.

On a specified date, the effectiveness of the plan of care, specifically the administration of medication, was not documented. [s. 6. (9) 3.]

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 plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the effectiveness of the plan of care is documented, to be implemented voluntarily.

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Issued on this 12th day of February, 2019

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

Original report signed by the inspector.