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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347 rue Preston bureau 420
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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
Jun 11, 2019	2019_665551_0009	032997-18, 033587-18, 002424-19, 002781-19	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

MEGAN MACPHAIL (551), JOELLE TAILLEFER (211)

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): April 17, 18, 25, 26, 30, May 1, 2 and 3, 2019.

The following logs were inspected:
- 032997-18 / C569-000069-18 related to an allegation of resident to resident abuse.
- 033587-18 / C569-000071-18 related to a medication incident/adverse drug reaction.
- 002424-19 / C569-000004-19 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.
- 002781-19 / C569-000005-19 related to an allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, the RAI Co-ordinator, the Registered Dietitian, a Pharmacist, Physicians, a Coroner, the Assistant VP of Nursing, the VP of Nursing and the President and CEO.

During the course of the inspection, the inspector(s) reviewed health care records, home's investigation files for specific Critical Incidents and the Medication Administration Policy, and observed staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

1 WN(s)
0 VPC(s)
1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication was administered to resident #005 in accordance with the direction for use specified by the prescriber.

A review of the Critical Incident Report (CIR) sent to the Ministry of Health and Long-Term Care on a specified date indicated that resident #005 was sent to the hospital due to a medication incident resulting in a significant change in the resident’s health condition.

The Admission Medication Orders and Reconciliation (Medscheck) and the Electronic Medication Management (eMeds) forms for resident #005 indicated to apply a specified type of medication patch daily.

The form titled Medication/Treatment Incident and Adverse Drug Event Reporting Tool for resident #005 indicated that the specified medication patch was applied daily but the old patches were not removed. The incident report indicated that the action taken was to clarify the physician's order by noting that the old patch should be removed daily.

In an interview with RPN #122 on May 1, 2019, the RPN indicated that they discovered medication patches on resident #005 on a specified date. RPN #122 revealed that RN #114 was asked during the morning shift that same day for further clarification of the medication order. The order indicated to apply the medication patch once a day but did not specify when to remove the patch. RPN #122 stated that RN #114 indicated to remove the old patch and to apply a new one. RPN #122 stated that the resident was lethargic on a specified date. On that day, the resident was seen by the physician and sent to the hospital.

In an interview with RPN #120 on May 1, 2019, the RPN revealed that there was no

instruction on when to remove the medication patch. The order only indicated to apply the medication at a specified time. Furthermore, RPN #120 revealed that the resident was not assessed for the presence of an additional patch before applying a new patch on a specified date.

In an interview with RPN #121 on May 2, 2019, the RPN stated that the resident's medication administration record (MAR) did not indicate when to remove the medication patch. The MAR only indicated when to apply the patch. RPN #121 stated that the resident's upper body was assessed, and there were no other patches discovered before the application of the new medication patch on a specified date.

In an interview with the VP of Nursing on May 2, 2019, it was stated that the medication error for resident #005 was immediately reported when the medication patches were discovered by RPN #122. The medication's order was immediately clarified with the physician. Resident #005 was sent to the hospital due to the resident's change in health condition. The VP of Nursing stated that an email was sent to all nurses related to the application of a specified medication patch. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	MEGAN MACPHAIL (551), JOELLE TAILLEFER (211)
Inspection No. / No de l’inspection :	2019_665551_0009
Log No. / No de registre :	032997-18, 033587-18, 002424-19, 002781-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 11, 2019
Licensee / Titulaire de permis :	St. Patrick's Home of Ottawa Inc. 2865 Riverside Drive, OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	St. Patrick's Home 2865 Riverside Drive, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Janet Morris

To St. Patrick's Home of Ottawa Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must achieve compliance with the requirement under O. Reg. 79/10, s 131. (2).

The licensee shall ensure that medications are administered as prescribed by:
1. Ensuring that registered nursing staff conduct a thorough visual verification of possible application areas before administering a medication delivered by a transdermal patch to ascertain that all patches previously applied have been removed in accordance with directions for use specified by the prescriber.
2. Ensuring that registered nursing staff document the exact location and time following the application and removal of a transdermal patch on the medication administration record.

Grounds / Motifs :

1. The licensee failed to ensure that a medication was administered to resident #005 in accordance with the direction for use specified by the prescriber.

A review of the Critical Incident Report (CIR) sent to the Ministry of Health and Long-Term Care on a specified date indicated that resident #005 was sent to the hospital due to a medication incident resulting in a significant change in the resident's health condition.

The Admission Medication Orders and Reconciliation (Medscheck) and the Electronic Medication Management (eMeds) forms for resident #005 indicated to apply a specified type of medication patch daily.

The form titled Medication/Treatment Incident and Adverse Drug Event Reporting Tool for resident #005 indicated that the specified medication patch

was applied daily but the old patches were not removed. The incident report indicated that the action taken was to clarify the physician's order by noting that the old patch should be removed daily.

In an interview with RPN #122 on May 1, 2019, the RPN indicated that they discovered medication patches on resident #005 on a specified date. RPN #122 revealed that RN #114 was asked during the morning shift that same day for further clarification of the medication order. The order indicated to apply the medication patch once a day but did not specify when to remove the patch. RPN #122 stated that RN #114 indicated to remove the old patch and to apply a new one. RPN #122 stated that the resident was lethargic on a specified date. On that day, the resident was seen by the physician and sent to the hospital.

In an interview with RPN #120 on May 1, 2019, the RPN revealed that there was no instruction on when to remove the medication patch. The order only indicated to apply the medication at a specified time. Furthermore, RPN #120 revealed that the resident was not assessed for the presence of an additional patch before applying a new patch on a specified date.

In an interview with RPN #121 on May 2, 2019, the RPN stated that the resident’s medication administration record (MAR) did not indicate when to remove the medication patch. The MAR only indicated when to apply the patch. RPN #121 stated that the resident’s upper body was assessed, and there were no other patches discovered before the application of the new medication patch on a specified date.

In an interview with the VP of Nursing on May 2, 2019, it was stated that the medication error for resident #005 was immediately reported when the medication patches were discovered by RPN #122. The medication’s order was immediately clarified with the physician. Resident #005 was sent to the hospital due to the resident’s change in health condition. The VP of Nursing stated that an email was sent to all nurses related to the application of a specified medication patch.

The severity of this issue was determined to be actual harm as resident #005 was admitted to the hospital with a significant change in condition. The scope was determined to a pattern as it related to three of five Registered Practical

Nurses involved in the medication incident. The licensee has a history of non-compliance under O. Reg. 79/10, s. 131 (2) that included a voluntary plan of correction being issued on June 25, 2018 (2018_617148_0016).

(551)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of June, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Megan MacPhail

Service Area Office / Bureau régional de services : Ottawa Service Area Office