Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 26, 2021	2021_548756_0001	017651-20, 018050-20, 018656-20, 020616-20, 021017-20, 021099-20, 022865-20, 024534-20	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

LISA CUMMINGS (756), EMILY PRIOR (732)

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 5-8, 11-13, 2021.

The following intakes were inspected during the Critical Incident System inspection:
- Log #020616-20: a critical incident (CI #3015-000028-20) of a fall that caused injury and a change in condition
- Log #018050-20: a critical incident (CI #3015-000022-20) of a fall that caused injury and a change in condition
- Log #021099-20: a critical incident (CI #3015-000030-20) of a fall that caused injury and a change in condition
- Log #024534-20: a critical incident (CI #3015-000035-20) of a fall that caused injury and a change in condition
- Log #018656-20: a critical incident (CI #3015-000025-20) of an allegation of resident abuse
- Log #022865-20: a critical incident (CI #3015-000033-20) of an incident which caused injury and a change in condition
- Log #017651-20: a critical incident (CI #3015-000020-20) of an allegation of resident abuse
- Log #021017-20: a critical incident (CI #3015-000029-20) of an allegation of resident abuse

During the course of the inspection, the inspector(s) spoke with the Vice President of Nursing, the Assistant Vice President of Nursing, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Companion Sitter, and residents.

During the course of the inspection, the inspectors also completed a review of several resident healthcare records including the plan of care, reviewed licensee internal investigation notes, conducted observations of the provision of resident care and services, of the interaction between residents and the interactions between staff and residents, and observed several resident rooms.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PSW provided care to the resident as set out in the resident's plan of care for personal care.

The resident clinical records identified the need for 2 staff member assistance for personal care and bed mobility.

The resident was provided personal care by the PSW without a second staff member present. While assisting the resident with personal care and repositioning in bed, the PSW heard a loud sound. The resident was assessed and although there was no injury identified at that time, the resident was later diagnosed with a injury that required a transfer to hospital.

The PSW acknowledged that the resident's plan of care detailed 2 staff assist for personal care and bed mobility and they chose to provide care without a second staff member present.

Sources: resident healthcare record including progress notes, and interviews with a PSW and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 9th day of February, 2021

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

Original report signed by the inspector.