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
Dec 14, 2021	2021_878551_0016	011755-21, 011972-21, 012708-21, 015946-21, 016979-21	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), JULIENNE NGONLOGA (502)

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): October 26, 27, 28 and 29, 2021 and November 1, 2, 3 and 4, 2021.

The following logs were inspected as part of this Critical Incident System (CIS) inspection:
- Log 011755-21 / CIS 3015-000021-21 was related to an incident of staff to resident abuse.
- Log 011972-21 / CIS 3015-000022-21 was related to the fall of a resident.
- Log 012708-21 /CIS 3015-000024-21 was related to the fall of a resident.
- Log 015946-21 / CIS 3015-000028-21 was related to an incident of resident to resident abuse.
- Log 016979-21 / CIS 3015-000031-21 was related to the fall of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Housekeepers, Registered Nursing Staff, a Physiotherapist Assistant, the Physiotherapist, a Restorative Care Worker, a Recreation Staff Member, the Screener, a Sitter, a Physician, the Human Resources Manager, an IPAC Lead and Skin and Wound Care Champion, the Assistant Vice President (A VP) of Nursing, the VP of Nursing and the Chief Operating Officer.

During the course of the inspection, the inspector(s) reviewed relevant documents, including residents' health care records and selected policies and procedures and observed the provision of care and services to residents, dining service, housekeeping services and COVID-19 Infection Prevention and Control measures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **5 WN(s)**
- **4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that daily symptom screening of all residents, including temperature checks was performed, as outlined in Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007.

In October 2021, there was no documented temperature check, on ten (10) days, for a resident.

In October 2021, the was no documented temperature check, on six (6) days, for a resident.

In August 2021, there was no documented temperature check, on 21 days, for a resident.

The VP of Nursing stated that temperature checks were to be documented in the Vital Signs module of PCC on a daily basis.

Sources: Residents' health care records and interview with the VP of Nursing. [s. 5.]

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 daily symptom screening of all residents, including temperature checks is performed, as outlined in Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Fall Prevention and Management policy and procedure included in the required Falls Prevention and Management Program were complied with.

O. Reg, s. 30 (1) requires an interdisciplinary program under section 48 of the Regulation.

O. Reg, s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy and procedure "Fall Prevention and Management", dated September 2020.

According to the Fall Prevention and Management procedure:
- The initial post-fall assessment, completed by the registered staff (RN/RPN), must include the following physical assessment for injuries: 3. Vital Signs – TPR and BP.
- Post Falls Assessment, the Registered Nurse will complete specific steps, including, 7. Document Post Fall Assessment in PCC, including the status of the resident, notification of the family, assessment and outcomes and interventions taken to prevent further falls or related injury.

A resident had a fall that was witnessed by a PSW. The resident was assessed for injury by an RPN. The RPN did not assess the resident's vital signs or complete a Post

Fall Assessment. The RPN did not report that the resident had fallen.

Several days after the fall, an injury was found on the resident, and they were sent to hospital.

Several days after the fall, the RPN reported the fall to the VP of Nursing, who was investigating the source of the injury, and wrote a Fall Incident Note as a late entry.

After the resident's fall, specific components of the Fall Prevention and Management policy, including taking the resident's vital signs, completing a Post Fall Assessment and notifications were not completed.

Sources: The resident's health care record, interview with an RPN and the Fall Prevention and Management Policy (IX NSG E-11.00, revised September 2020). [s. 8. (1)]

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 Fall Prevention and Management Policy is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was prescribed medications to be administered at a specific time.

The resident's medications were not signed for on the eMAR as being administered. The A VP of Nursing stated that the standard was that, if the medication was not signed for, it was not administered.

Sources: A resident's heath care record and interview with A VP of Nursing. [s. 131. (2)]

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 drugs are administered to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to the Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, “Just Clean Your Hands (JCYH)”.

During meal service, the inspector did not observe PSWs and a sitter assist four (4) residents to clean their hands before eating their meal. The RPN who supervised the dining room did not remind staff to assist resident perform hand hygiene.

As such, there was a potential risk to residents of being impacted by cross-contamination if their hands were unclean.

Sources: Direct observations and staff interviews. [s. 229. (4)]

2. It was observed that two (2) PSW staff had assisted a resident, who was on contact precautions, to the toilet. The 2 staff did not remove their gloves and perform hand hygiene before entering another room to assist a resident.

An RPN exited a room where the resident was on contact droplet precautions. The RPN performed hand hygiene in the lounge care while carrying a pen, with a closed hand, for approximately 3-5 seconds.

Three (3) PSW staff exited the washroom in the lounge area after assisting a resident with continence care. All 3 staff were wearing gloves. One staff member was observed removing their gloves and did not perform hand hygiene before escorting another resident to the washroom.

The VP of Nursing stated that soiled gloves should be removed, and hand hygiene should be performed after the removal of the gloves. The IPAC Lead stated that hand hygiene should be performed for fifteen seconds.

Sources: Interviews with the VP of Nursing and IPAC Lead and observation of the inspector. [s. 229. (4)]

3. The licensee has failed to ensure that staff don, doff and discard PPE correctly and wear the required PPE where necessary in accordance with evidence-based practices, specifically Public Health Ontario - Routine Practices and Additional Precautions In All Health Care Settings, 3rd edition, November 2012.

It was observed that 2 PSW staff had assisted a resident, who was on contact precautions, to the toilet. The two staff were wearing gloves and no gown.

A resident's one-to-one (1:1) companion was within 2 meters of the resident who was on contact droplet precautions. The 1:1 companion was not wearing eye protection, a gown or gloves. The RPN stated that the resident was on contact droplet precautions, and the 1:1 companion should have been wearing eye protection, a gown and gloves.

Two PSW staff were assisting a resident, who was on contact precautions, to the toilet. The staff were wearing gloves and no gown. They did not remove their gloves and perform hand hygiene before making the resident's bed wearing soiled gloves.

The VP of Nursing stated that an isolation gown should be worn for direct contact with a resident on contact precautions, and that soiled gloves should be removed, and hand hygiene should be performed after the removal of the gloves, following completion of the direct care task.

A PSW exited the room of a resident was on contact droplet precautions. The PSW was wearing eye protection, a gown and gloves. The PSW did not doff their PPE prior to exiting the room. The PSW walked down the hallway towards the dining room area, then reentered the room.

The IPAC Lead stated that staff should doff PPE in the resident's room and not wear PPE in the hallway.

Sources: Interview with the IPAC Lead and observations of the inspector. [s. 229. (4)]

4. The licensee has failed to ensure that a piece of shared equipment was disinfected after it was used on a resident who was on contact droplet precautions in accordance with evidence-based practices, specifically Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018.

An RPN exited the room of a resident was on contact droplet precautions. The RPN was pushing the blood pressure machine. The RPN plugged in the machine in the lounge area. The blood pressure machine was not disinfected. No disinfecting wipes or spray were observed outside of the resident's or on the machine.

Sources: Observations of the inspector, Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018. [s. 229. (4)]

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 hand hygiene is performed in accordance with evidence based practices,
to ensure that staff don, doff and discard PPE correctly and wear the required PPE where necessary and
to ensure that shared pieces of equipment are disinfected in between uses, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a critical incident no later than 1 business day after the occurrence of the incident, as required under r. 107 (4), subject to (3.1).

A CIS was submitted to report an injury of unknown case. The date and time of the incident could not be confirmed.

It was known that there was a significant injury on the day that the resident was sent to hospital. The CIR was not submitted until over 2 weeks later.

Sources: CIR 3015-000031-21, the resident's health care record and interview with the A VP Nursing. [s. 107. (3)]

Issued on this 20th day of December, 2021

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

Original report signed by the inspector.