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 9, 2021	2021_878551_0015	013621-21, 014284-21	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint 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 complaint inspection:
- Log 013621-21 was related to concerns about the care of a resident.
- Log 014284-21 was related to concerns about the care of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, a Physician, the Skin and Wound Care Champion, the Assistant Vice President (VP) of Nursing, the VP of Nursing and the Chief Operating Officer (CEO).

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1-3. The licensee has failed to ensure that residents received a skin assessment by a member of the registered nursing staff upon return from hospital.

Three (3) residents who exhibited altered skin integrity or were at risk for altered skin integrity returned from hospital. A review of the 3 residents' health care records indicated that a skin assessment was not completed upon their return from hospital. [s. 50. (2) (a) (ii)]

The VP of Nursing stated that a head to toe assessment was to be conducted upon a resident's return from hospital.

Sources: Residents' health care records and interview with the VP of Nursing. [s. 50. (2) (a) (ii)]

4. The licensee has failed to ensure that residents received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound.

The Assistant VP of Nursing and the Wound Care Champion stated that residents exhibiting altered skin integrity were to receive a skin assessment on a weekly basis by a member of the registered nursing staff.

A resident required treatment for a skin condition. A review of the resident's health care record indicated that a skin assessment was completed for areas of altered skin integrity to multiple body parts. During a four (4) month period, a skin assessment was completed on five (5) occasions, and not on a weekly basis.
[s. 50. (2) (b) (i)]

5. A resident exhibited altered skin integrity. A review of the resident's health care record indicated that a skin assessment was completed for areas of altered skin integrity to multiple body parts. The assessments were not consistently completed for each area of skin impairment on a weekly basis.

Sources: Residents' health care records and interviews with the Assistant VP of Nursing and the Skin and Wound Care Champion. [s. 50. (2) (b) (i)]

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 residents receive a skin assessment by a member of the registered nursing staff upon any return from hospital; and that residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a piece of equipment was kept in good repair.

LTCHA, 2007, s. 15 (1) (c) requires an organized program of maintenance services for the home.

O. Reg 79/10, s. 90 (2) (b) requires that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

A resident's catheter did not have output. Staff were unable to use the scanner to assess the lack of output as the scanner was not working.

A physician stated that if a resident's catheter was not draining, it could be because the resident had a medical condition, the catheter was blocked or the catheter was being bypassed. They stated that without a scanner, the cause of no output could not be determined.

The VP of Nursing stated that the home's scanner was not functioning for approximately one month.

The cause of the resident's lack of output could not be determined in the absence of a scanner. The home's scanner was not functioning and sufficient action had not been taken to ensure that the piece of equipment was kept in good repair.

Sources: A resident's health care record and interviews with a physician and the VP of Nursing. [s. 90. (2) (b)]

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.