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
May 13, 2022	2022_548756_0003	003733-22, 005360-22	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

LISA CUMMINGS (756), PAMELA FINNIKIN (720492)

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): March 8-11, 14-16, 21-24, 2022.

The following intakes were completed during the Complaint inspection:
- Log #003733-22 and log #005360-22 regarding complaints that staff were not providing care related to choice and privacy as per resident's plan of care.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer (CEO), the Assistant Vice President of Nursing (AVP of Nursing), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a housekeeper, and a resident.

During the course of the inspection, the inspector observed residents and staff interactions, the provision of care and services and resident home areas. A review of relevant records was completed including resident health records, internal email communication and policy #I ADM F. 16.00 Complaint Management, Revised August 2020.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Personal Support Services

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 care set out in the plan of care related to a resident's request for choice and privacy was provided.

The resident's plan of care set out direction for how to enter the resident's room.

Two separate incidents occurred on a night shift where staff entered the resident's room without following the resident's plan of care.

An RN confirmed that a PSW was aware of the resident's care plan and specific requests related to caregivers. An RPN stated that the previous progress notes in Point Click Care were that the resident was on a leave of absence and there was no documentation that the resident had returned, therefore, they thought the resident was not in their room. The RPN also stated that they did not know the resident or check the residents plan of care prior to entering the resident's room.

Sources: Resident health care record including progress notes and resident's care plan, internal emails, observation of signage outside of resident's room, interviews with staff members. [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 that 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 26th day of May, 2022

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

Original report signed by the inspector.