Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: May 3, 2023	
Inspection Number: 2023-1510-0004	
Inspection Type: Complaint	
Licensee: St. Patrick's Home of Ottawa Inc.	
Long Term Care Home and City: St. Patrick's Home, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.05.11 08:45:06 -04'00'
Additional Inspector(s) Gurpreet Gill (705004)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 27-31, 2023

The following intake(s) were inspected:

- Intakes: #00010840 and #00017060 Complaints related to care concerns of a resident

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the resident's plan of care was

documented.

Rationale and Summary

The resident was scheduled to receive a bath or shower twice weekly, as per their plan of care. The point of care (POC) documentation for the resident showed that for the month of December 2022 there were two days, and for the month of February 2023 there was one day where the resident's bath was not documented.

During an interview, an RPN indicated that the resident received their scheduled twice weekly baths, but it was not documented in POC. Therefore, the provision of care set out in the resident's plan of care regarding the bath was not documented.

Sources: The resident's health care records and interview with an RPN.

[705004]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control, specifically related to the interventions for the prevention and control of antibiotic-resistant organisms.

Rationale and Summary

The resident's clinical records described that they tested positive for a bacterial infection in September 2022.

An interview with an RN indicated that the resident was not re-screened as per the Long-Term Care Home's (LTCH) protocol. The resident was supposed to be re-screened for the bacterial infection in March 2023, six months after the initial swab as per the protocol.

Sources: The resident's health care records, the Provincial Infectious Diseases Advisory Committee (PIDAC): Annex A- screening, testing and surveillance for Antibiotic-Resistant Organisms (AROs) /January

2013, and interview with an RN.

[705004]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs administered to a resident were in accordance with the directions for use specified by the prescriber.

Rationale and Summary

In November 2022, a resident was prescribed a specific medication daily for fourteen days.

A review of the resident's electronic Medication Administration Record (eMAR) in November 2022, for the administration of the prescribed medication, showed there were no initials in the eMAR to indicate whether the prescribed medication was administered as directed on the specified days in November 2022.

The eMAR for November 2022, indicated that the resident was administered the prescribed medication in November 2022, seven days after the medication was prescribed by a physician.

During an interview, the RN indicated that the order was missed and was sent late.

Failure to administer the medication to the resident as prescribed put the resident at increased risk for potential delay in treatment.

Sources: The resident's health care records and interview with an RN.

[705004]