Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 9, 2023
Inspection Number: 2023-1510-0005
Inspection Type: Complaint Critical Incident System
Licensee: St. Patrick's Home of Ottawa Inc.
Long Term Care Home and City: St. Patrick's Home, Ottawa

Lead Inspector	**Inspector Digital Signature**
Cheryl Leach (719340)	
Additional Inspector(s) Erica McFadyen (740804)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 22, 23, 26, 27, 28, 29, 2023 and July 4, 5, 6, 7, 10, 11, 12, 13, 14, 2023

The following intake(s) were inspected:

- Intake #00021554 [CI 3015-000015-23] Injury resulting in a transfer to hospital and a significant change in condition.
- Intake #00022072 [CI 3015-000018-23] Complaint about transfer with mechanical lift.
- Intake #00022077 [CI 3015-000017-23] Complaint about transfer with mechanical lift.
- Intake #00083808 [IL-11235-OT] Complaint concerning the CPAP.
- Intake #00084685 [CI 3015-000024-23] Fall with injury resulting in a transfer to hospital and a significant change in condition.
- Intake #00086289 [eCorrespondence-245-2023-1156-OD] Complainant with concerns regarding alleged neglect, weight loss, fall, plan of care, dental care and documentation.
- Intake #00086531 [CI 3015-000036-23] Alleged staff to resident neglect.
- Intake #00086546 [IL-12546-OT] Complaint regarding frequent falls, feeding and need for more assistance from staff.
- Intake #00087081 [IL-12781-OT] Complaint regarding alleged neglect from physician.
- Intake #00088596-Complaint regarding allergies, staff refusing to accommodate and no air conditioning in the home.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

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 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident to be up from their bed was provided as specified in the plan.

Rationale and Summary
Upon review of the current plan of care, it was noted that a resident was to be up from their bed during the day. Point of Care (POC) documentation during a 30 day period indicated that the resident was not up from their bed on several occasions during this time period. As per interviews with staff, it was confirmed that the resident was not up from their bed everyday. Failure to ensure that the plan of care is followed for the resident to be up from their bed during the day increases risk for impaired skin integrity and altered psychosocial wellbeing.

Sources
Resident's care plan, POC documentation and physician orders and interviews with staff.

[719340]

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (1) (b)

The licensee has failed to ensure that their procedure for the reporting of broken equipment under the licensee's organized program of maintenance was complied with.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure that their procedure related to the maintenance of broken equipment is complied with. The licensee did not comply with their procedure while providing care to a resident.

Rationale and Summary
During an observation of the room of a resident it was observed that the head of the bed would not fully raise or lower. During an interview with a staff member it was stated that the head of the bed was broken and would only raise a quarter of the way and that the bed had been broken for at least a month. The staff member stated that it was more difficult to care for the resident when the head of the bed would not raise. The staff member stated that they had not reported the broken bed to anyone during the one month that it had been broken.

During an interview with the Manager of Building Services it was stated that the procedure for reporting broken equipment is reviewed in person at orientation and that staff are expected to report broken equipment by completing a WORXHUB online requisition. During an interview with the Manager of Building Services Manager it was stated that no WORXHUB requisitions were completed regarding the bed of the resident. The procedure in place for remedial maintenance was not followed by the staff member and as a result the maintenance team was not aware of the resident's broken bed for at least one month.

The risk of staff not following the process for remedial maintenance in the long-term care home is that when equipment is broken it may not be fixed in a prompt manner.

Sources
Observations of the resident, interviews with staff member and the Manager of Building Services and record review of WORXHUB requisition process.

[740804]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
As documented in the Critical Incident Report, it was reported to a staff member by a tablemate of a resident that a staff member had spoken to the resident in an abusive way. Record review of a correspondence between the staff member and the Assistant Vice President of Nursing showed that the allegation of abuse had not been reported immediately. This was confirmed during an interview with the Assistant Vice President of Nursing. The Director was not immediately notified of staff to resident alleged abuse.

The risk of not reporting alleged abuse immediately to the Director is that it may delay investigation and follow up into reports of abuse and leave residents at risk of additional harm.

Sources
Interview with the Assistant Vice President of Nursing, record review of Critical Incident Report, record review of correspondence between staff member and the Assistant Vice President of Nursing and clinical record review of resident.

[740804]

WRITTEN NOTIFICATION: Compliance with Manufacturers' Directions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary
During an observation of the room for a resident it was noted that the head of the bed was broken and could not be fully laid flat or raised.

The Use and Care Manual for Advantage High-Low Beds stated that the bed used by the resident and other residents in the long-term care home should be reviewed every six months to ensure they

remained in good working order. In an interview with the Manager of Building Services it was stated that bed audits had not been completed for the long-term care home since at least 2020. In an interview with the Manager of Building Services it was confirmed that the manufacturers' directions for the Advantage Hi-Low Beds was not complied with.

The risk of the beds not being audited in adherence with the manufacturer's directions is that broken or malfunctioning beds may not be discovered, as was the case with the bed of the resident. Broken beds can place residents at risk of harm.

Sources
Observation of the bed of the resident, interviews with the Manager of Building Services and review of the Use and Care Manual for Advantage High-Low Beds

[740804]

WRITTEN NOTIFICATION: Plan of Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 3.

The licensee has failed to ensure that the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's communication abilities, including hearing and language.

Rationale and Summary
A resident was observed in the dining room with their adaptive device not in place. During an interview with a staff member it was stated that they were unsure of what adaptive device plan of care was in place for the resident. During a review of the care plan for the resident, no communication, hearing, or language plan of care was in place.

During an interview with the Assistant Vice President of Nursing it was stated that the staff on the floor were unsure if they should use the adaptive device for the resident and that the plan of care did not include communication, hearing, or language.

The risk of not having a communication, hearing, and language care plan in place for the resident is that it may be difficult for the resident to communicate their needs.

Sources
Interview with staff member and Assistant Vice President of Nursing, review of the clinical record for the resident and observations of the resident.

[740804]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times when not in use.

Rationale and Summary
During an observation of the bedroom of a resident it was observed that medications were stored unsecured in the resident's bathroom.

In an interview with a staff member it was stated that the resident had medications stored unsecured in their bathroom and that this was not the correct process for storing medications in the home. In an interview with the Assistant Vice President of Nursing it was stated that medication for residents should be secured in the medication room and should not be stored in resident rooms.

The risk of unsecured medications in the long-term care home is that medications may be administered to residents in a way that is not prescribed.

Sources
Observation of the resident bathroom, interviews with staff member and the Assistant Vice President of Nursing.

[740804]