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

Original Public Report

Report Issue Date: November 14 2023	
Inspection Number: 2023-1510-0008	
Inspection Type: Complaint Critical Incident	
Licensee: St. Patrick's Home of Ottawa Inc.	
Long Term Care Home and City: St. Patrick's Home, Ottawa	
Lead Inspector Jessica Nguyen (000729)	**Inspector Digital Signature** Jessica Nguyen Digitally signed by Jessica Nguyen Date: 2023.11.28 09:12:11 -05'00'
Additional Inspector(s) Martin Orr (000747) Linda Harkins (126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 19-20, 23 and 25-27, 2023.

The following intakes were inspected during this complaint inspection:

Intake: #00098781 – related to Infection Prevention and Control concerns.
Intake: #00099081 – related to catheter care, masking and fall management.

The following intakes were inspected during this Critical Incident (CI) inspection:

Intake: #00094169/CI# 3015-000060-23 – was related to alleged resident to

resident sexual abuse.
Intake: #00094765/CI#3015-000065-23 – was related to alleged resident to resident physical abuse resulting in injury.
Intake: #00095001/CI# 3015-000067-23- was related to alleged resident to resident physical abuse resulting in injury.
Intake: #00097549/ CI#3015-000073-23 – was related to alleged resident to resident physical/emotional abuse.
Intake: #00098495/CI# 3015-000077-23 – was related to an incident that caused injury that led to hospitalization and significant change in condition.
Intake: #00099048/CI# 3015-000078-23 – was related to a fall with injury resulting in a significant change in condition.

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

Resident Care and Support Services
Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviors

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to, ensure that, when a resident is demonstrating responsive behaviors, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Summary and Rationale

On a specified date, a resident sustained an injury during evening care. This was immediately reported to registered staff and upon assessment there were no visible injury noted or any indication of pain. The next day, the resident was experiencing pain and the area was notably swollen and bruised. The resident was assessed, a diagnostic procedure was ordered, and they were transferred to hospital.

Record review indicated that no documentation regarding incident was completed after the incident by the registered staff until a later date. The registered staff failed to report the incident to the charge nurse, the on-call physician, and the on coming staff. No reassessment of the resident's responsive behaviors was completed or documented.

The resident's most current care plan indicates that the resident can display responsive behaviors and can be resistive to care, specific interventions were listed but not implemented for their responsive behaviors. The resident was not reassessed after the incident as care plan does not indicate any new interventions.

An internal investigation was completed by the Assistant VP of Nursing, and it was found that the resident sustained an injury after exhibiting responsive behaviors during evening care with a PSW. The resident was not reassessed after incident as care plan does not indicate any new interventions and no documentation was

completed.

During an interview with registered staff, it was confirmed that a PSW reported to them the incident immediately, and upon assessment the registered staff saw no visible injuries or any indications of pain. The registered staff confirmed no documentation was completed that night regarding incident due to time constraints and that the incident was not reported to the charge RN because they couldn't reach them. The registered staff confirmed that the on-call physician and on coming staff were not notified because they thought the resident was fine. The registered staff stated it can be difficult to differentiate between the resident calling out as part of their responsive behaviors and calling out in pain. The registered staff could not recall if a follow up pain assessment was completed.

By not ensuring that, when a resident is demonstrating responsive behaviors, that actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, resident was put at an increased risk of having unmanaged pain and a decrease quality of life.

Sources:

Interview with registered staff
Resident's electronic chart
Internal investigation notes

[000729]

COMPLIANCE ORDER CO #001 Infection prevention and control program

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

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

To ensure compliance with the IPAC standard the licensee must:

A) Ensure all housekeeping staff on Dublin unit are routinely checking Alcohol based hand rub (ABHR) dispensers at the entrance of the unit and changing as needed.

B) Ensure all staff on Dublin unit are aware to notify housekeeping staff immediately, when an ABHR dispenser requires changing.

C) Ensure when required, Personal Protective Equipment (PPE) carts are available and fully stocked at point of care.

D) Conduct two audits per week for four weeks of the following:

I) The registered staff during medication pass on two specific units to ensure all staff are performing hand hygiene at, but not limited to the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

II) The direct care staff at varying meal times on two specific units to ensure all staff

are performing hand hygiene at, but not limited to the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

III) The ABHR dispenser at the entrance of Dublin unit to ensure product is available.

E) If non compliance is identified with any of the required actions under (A) (B) (C) and (D), the relevant staff members must be provided education and training.

F) A written record must be kept of everything required under (A) (B) (C) (D) and (E).

Grounds

The licensee has failed to ensure the implementation of a standard or protocol issued by the Director with respect to infection protection and control, specifically section 9.1 (b) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard) related to performing hand hygiene, including, but not limited to, at the four moments of hand hygiene and section 6.1 related to making PPE available and accessible to staff and residents, appropriate to their role and level of risk.

Summary and Rationale

Section 9.1 (b) of the IPAC Standard states that the licensee shall ensure that Routine Practices are followed in the IPAC program. At minimum Routine Practices shall include hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment

contact).

Section 6.1 of the IPAC Standard states that the licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions.

During observations, a registered staff on a specific unit was observed preparing and administrating medication to three different residents and not performing hand hygiene in between residents. A direct care staff on a specific unit was observed assisting twelve residents with clothing protectors and servings drinks to residents and not performing hand hygiene. On a specific unit, a resident room on additional precautions was observed to not have appropriate PPE available. Another resident room on additional precautions was observed with no PPE cart in front of room. A registered staff on a specific unit was observed preparing and administering medication to a resident, going to help another resident down the hall, then returning to document on the medication cart and not performing hand hygiene in between. On specific unit, a resident room on additional precautions was observed without the appropriate PPE available.

According to the Policy: Infection prevention and Control: Hand Hygiene (VI IPC 11.00) last reviewed on October 2023 hand hygiene should be completed before resident/environment contact, before any procedure, after body fluid exposure and after resident/environment contact.

VP Nursing confirmed that staff are expected to perform hand hygiene at least at the four moments of hand hygiene such as: prior and after administrating medication and during mealtimes in between contact with residents.

VP Nursing confirmed that PPE carts are to be available and fully stocked with PPE outside resident rooms that require additional precautions.

By not ensuring that all required PPE is readily available at the point of care and that all staff are performing hand hygiene at the four moments of hand hygiene, staff and residents are placed at increased risk of contracting an infectious disease.

Sources:

Observations of staff and resident rooms.
Interview with VP Nursing.
MLTCIB Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022.
Policy: Infection prevention and Control: Hand Hygiene (VI IPC 11.00) last reviewed on October 2023.

[000729]

The licensee has failed to ensure the implementation of standard or protocol issued by the Director with respect to infection prevention and control.

The Director issued the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes" in April 2022. Additional Requirement 9.1 of the IPAC Standard requires the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include:
e) Use of controls, including: I. Environmental controls, including but not limited to, location/placement of residents' equipment, cleaning, making hand hygiene products available.

Specifically, the licensee failed to ensure that hand hygiene product was available upon entering and exiting Dublin Unit.

During an observation, it was noted that hand hygiene product was not available in the hand sanitizer dispenser upon entering and exiting Dublin Unit.

Interview with VP of Nursing confirmed that hand hygiene should be done when entering and exiting the units. VP of Nursing confirmed that when the hand hygiene product dispenser was empty, staff would notify housekeeping staff and the dispenser would be refilled.

By not doing hand hygiene upon entering and exiting Dublin Unit, there is a potential risk of transmission of infections.

Sources:

Observations of ABHR dispenser and interview with VP of Nursing.

[126]

This order must be complied with by January 8, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.