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

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Original Public Report

Report Issue Date: November 22, 2024
Inspection Number: 2024-1510-0007
Inspection Type: Complaint Critical Incident
Licensee: St. Patrick's Home of Ottawa Inc.
Long Term Care Home and City: St. Patrick's Home, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8, 12-15, 18-22, 2024.

The following complaint intake(s) were inspected:
• Intake #00128403 - related to care concerns of a resident
• Intake #00128833 and Intake #00129033 - related to concerns regarding responsive behaviours of a resident
• Intake #00129514 - related to concerns regarding staffing and linen availability
• Intake #00129927 - related to concerns regarding medication administration, wound assessment, and plan of care

The following critical incident intake(s) were inspected:
• Intake #00128977 / CI #3015-000065-24- related to resident to resident alleged sexual abuse

The following Inspection Protocols were used during this inspection:

Continence Care
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours
Skin and Wound 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)
Plan of care
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.

1. The licensee has failed to ensure that the care set out in the plan of care for a resident's catheter care was followed by direct care staff.

Sources: Resident's electronic health records including care plan and progress notes on Point Click Care documentation system, and interview with RPN.

2. The licensee has failed to ensure that the care set out in the plan of care related to a resident's dressing was followed by direct care staff.

Sources: Resident's progress notes on Point Click Care documentation system, interviews with DOC and other staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff. Staff confirmed that registered staff are expected to complete skin and wound assessments at minimum weekly for this resident's injury.

Sources: Resident's electronic health records, interviews with Wound Care Champion and other staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246 / 22, s. 102 (2).

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 (d) of the Infection Prevention and Control Standard for Long Term Care Homes (IPAC Standard) related to proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

Sources: Observations and interview with IPAC Lead.

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to administer a drug to a resident in accordance with the directions for use specified by the prescriber. Specifically, a resident was administered a lower dose of a drug than prescribed on one occasion.

Sources: Resident's electronic health records, interviews with RN and other staff.