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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Public Report

Report Issue Date: July 25, 2025

Inspection Number: 2025-1510-0003

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 on the following dates: July 8, 9, 10, 11, 15, 16, 17, 18, 22, 23, 24, 2025

The following intakes were completed during this inspection:

- Intake: #00147587 was related to concerns regarding the plan of care of a resident.
- Intake: #00149051 was related to concerns regarding care of a resident.
- Intake: #00150260 was related to concerns regarding management of a resident's responsive behaviours.
- Intake: #00151203 was related to concerns regarding meal service.
- Intake: #00146466 was related to a written complaint with concerns regarding the care of a resident.
- Intake: #00147142 was related to an injury of a resident of unknown cause.
- Intake: #00147513 was related to a written complaint with concerns regarding the care of a resident.
- Intake: #00148931 was related to a fall of a resident that resulted in a significant change in health status.

- Intake: #00149649 was related to an incident of alleged staff to resident improper care.
- Intake: #00149730 was related to an incident of alleged staff to resident physical abuse.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that the response to a person who made a complaint included the hours of service for the Ministry's toll-free number for making complaints about homes.

Sources: The review of a complaint response letter and interview with the Administrator.

Date Remedy Implemented: July 16, 2025

WRITTEN NOTIFICATION: Integration of assessments, care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

A) The licensee has failed to ensure that staff collaborated with each other in the assessment of a resident when they presented with new symptoms, post hospitalization for a specified diagnosis. A Registered Practical Nurse (RPN) reported notifying a Registered Nurse (RN) of the resident's possible change in condition. The

RN stated the communication did not occur, as there was no corresponding documented assessment by them. The resident went to hospital the following morning and was diagnosed with a subacute specified diagnosis.

Sources: A resident's health records and interviews with RPN and RN.

B) The licensee has failed to ensure that staff collaborated with the physician in the assessment of a resident on a specified date, when the resident presented with several new symptoms after a two day period when a specified symptom began. A Registered Practical Nurse (RPN) reported notifying a Registered Nurse (RN) of the resident's change in condition. The RN stated they did not communicate with any on-call physician on those dates regarding their deterioration in condition. The resident was sent to the hospital a few days after, with specified diagnoses and the resident passed away a week later.

Sources: A resident's health care records; interviews with resident's family, RPN, two RNs and the Director of Care.

WRITTEN NOTIFICATION: Plan of care

NC #003 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.

The licensee has failed to ensure that the morning care provided to a resident on a specified date was provided to the resident as specified in the plan of care. Specifically, the resident's plan of care indicated that they required two person

assistance for care. On the specified date, a Personal Support Worker (PSW) provided care to the resident without a second staff member to assist.

Sources: A resident's care plan, internal investigation notes; and interview with Director of Care.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that the full assessment of a resident, in the form of head injury routine, initiated following an injury of unknown cause, was documented.

Sources: A resident's heath care records and interview with the Assistant Vice President of Nursing.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring techniques when assisting a resident. Specifically, the resident's plan of care stated they required two person assistance with a full lift for transfers. On a specified date, the PSW transferred the resident using a full lift without a second staff member.

Sources: Licensee's internal investigation notes, a resident's plan of care; and interview with Director of Care.

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure injuries, and provide effective skin and wound care interventions.

The licensee has failed to ensure that their skin and wound care program to promote skin integrity and provide effective skin and wound care interventions was implemented for a resident in the home.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home's skin and wound care assessment and documentation policy titled Skin,

Wound care, Nutrition, Hydration program #IX NSG E 10.00 and procedures related to this policy, were complied with.

Specifically, the home's skin and wound policy and procedures indicated all wounds require a photo and completed skin and wound assessment and that these assessments are required weekly. These assessments require registered nursing staff to identify the wound's anatomical location using description, ensure consistent wound measurements for each repeated re-assessment, and provide assistance to stabilize an area when it is in an awkward spot to ensure accurate pictures and assessment details are completed. Once a wound site is clear, take a picture of the specific site and resolve- sign and lock assessment.

Registered nursing staff did not comply with the home's skin and wound program policy and procedures regarding these areas, for a resident's wounds.

Sources: A resident's health care records, policy and procedures for skin and wound program; interviews with RPN, and two RNs.

WRITTEN NOTIFICATION: Skin and wound care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident that exhibited altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, received a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

On a specified date, a resident was identified to have skin breakdown to an areas and no assessment was completed until a couple months after the inspector brought this to the home's attention.

Sources: A resident's health care records; observation; interviews with the resident, RN and the Assistant Vice President of Nursing.

WRITTEN NOTIFICATION: Skin and wound care

NC #008 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 exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly by an authorized person, if clinically indicated.

The resident's wound located in a specified area, was not assessed weekly between

during specified intervals during a couple months, whereby the resident's wound had deteriorated.

Sources: A resident's health care records; interviews with RPN, RN and the Assistant Vice President of Nursing.

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that the planned menu items for the a la carte menu were offered and available to residents who required texture modified diets. A Food Service Supervisor (FSS) acknowledged that the hamburger, macaroni and cheese, and chicken breast options on the a la carte menu were only available to residents on regular textured diets.

Sources: A la carte menu, observations and interview with FSS.