Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 2, 2013	2012_198117_0011	O-000354-12 + 3	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

Long-Term Care Home/Foyer de soins de longue durée

PETER D. CLARK CENTRE
9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 17, 18 and 19 2012

It is noted that four critical incident inspections were completed during this inspection: logs # O-000354-12, #O-001041-12, #O-001615-12 and #O-001653-12.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Clinical Care Coordinator, a physician, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), a housekeeper, several residents and to several family members.

During the course of the inspection, the inspector(s) reviewed the health care records for four identified residents; observed resident care and services; examined an identified resident's wheelchair, lap belt and lap tray; reviewed four Critical Incident Reports; reviewed the home's Abuse Policy #750.65, last revised in November 2012 and the home's 2012 Staff Education calendar.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Hospitalization and Death

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6 (7) in that the care set out in the plan of care was not provided to the resident as specified in the plan.

Resident #1's plan of care identifies that he/she has a lap tray with back closure restraint that is to be applied when the resident is up in his/her wheelchair. Resident #1 also has a lap belt PASD (Personal Aid Safety Device) that is to be applied in conjunction with the lap tray restraint.

On a specified day in July, 2012, a PSW had assisted Resident #1 with his/her morning care. After the care, Resident #1 was transferred and seated in his/her wheelchair. The lap belt PASD was applied but the lap tray restraint was not applied. Resident#1 's family member found the resident on the bathroom floor in another co-resident's room. The resident had undone the PASD lap belt and had fallen out of the wheelchair.

Post fall assessments were initiated. Resident #1 did not sustain any visible injuries however, changes were noted in the resident's condition later in the day. Resident#1 was transferred to hospital for further assessment.

The PSW did not apply Resident#1's lap tray restraint as specified in the resident's plan of care. (log # O-001653-12) [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10 s. 107 (4) in that three written Critical Incident Reports, submitted to the Director, did not include the analysis and follow-up actions, including: i) the immediate actions that have been taken to prevent recurrence, and ii) the long-term actions planned to correct the situation and prevent recurrence.

On a specified day in July 2012, the home submitted a Critical Incident Report related to Resident #1's fall, injury and transfer to hospital. The home did not amend the critical incident report to include the home's analysis on the incident and actions taken to prevent recurrence of such an incident. (log # O-001653-12)

On a specified day in April 2012, the home submitted a Critical Incident Report related to Resident #3's report of an incident of alleged neglect. The home did not amend the Critical Incident Report to include the results of the home's internal investigation into the alleged incident of neglect and actions taken by the home. It is noted that no evidence of neglect was found. (log # O-001041-12)

On a specified day in July 2012, the home submitted a Critical Incident Report related to Resident #4 and an incident of resident to resident abuse. The home did not amend the Critical Incident Report to include the results of the home's internal analysis into the incident and actions taken to prevent the recurrence of such an incident. (log # O-001615-12) [s. 107. (4) 4.]

Issued on this 2nd day of January, 2013

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs