Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2016	2016_284545_0006	000661-16	Complaint

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 2, 3 & 4, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Personal Care Workers, Program Manager of Nursing, Food Services Supervisor (FSS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), Food Services Attendants (FSA), Staffing Coordinator, one Activities Coordinator, one Volunteer, a family member and Residents.

The inspector also reviewed Resident #001's health care records, home policies and procedures related to restraints and complaints, staff work routines and schedules, observed Resident #001's room, observed Resident common areas, observed two meal services, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

Upon review of the home's complaints record, four written complaints had been submitted by Resident #001's POA, using the Compliment/Complaint Form #750.43:
-a specific date in October 2015: concern related to staff creating obstacles to Resident #001's independence
-a specific date in October 2015: concern related to how Resident #001 is dressed at night time
-a specific date in October 2015: related to staff using a wheelchair with a seatlbelt to restrain Resident #001
-a specific date in December 2015: related to staff using a wheelchair with a seatlbelt to restrain Resident #001

The Inspector interviewed Program Manager #102 who dealt with the three complaints received in October and with Program Manager #101 who dealt with the complaint received in December 2015. Both program managers indicated that they had not forwarded the written complaints to the Director.

In discussion with the Administrator, he indicated that he was not aware of the requirement to immediately forward written complaints received concerning the care of a resident or the operation of the home to the Director. He confirmed that all four written complaints submitted by Resident #001's POA had not been forwarded to the Director, as per legislation. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints made to the licensee or a staff member concerning the care of Resident #001 or operation of the home were investigated, resolved where possible, and responses provided within 10 business days of receipt of the complaint.

On a specific date in December 2015 Resident #001's POA submitted a written complaint to the home, using Compliment/Complaint Form 750-43 related to an observation of Resident #001 placed in a wheelchair with a seatbelt, and brakes on. The resident was noted to be struggling to get out of the wheelchair, exhibiting agitation, with no staff nearby.

In reviewing the Compliment/Complaint Form, it was noted that the POA was not provided with an acknowledgement within 10 business days of receipt of the complaint.

Under the section "Final Resolution" completed by Program Manager #101, it was noted that the care plan was reviewed with the POA on a specific date in February 2016; which was two months following receipt of the written complaint.

During an interview with Program Manager #101, she indicated that she had been appointed contact person to communicate with Resident #001's family/POA. She indicated that she normally used an "Interaction Log-Person Specific" form to document: date, time (approx), method of communication, memo, follow-up when following up on complaints, however in this situation, she had not used this form and was unable to provided evidence to demonstrate acknowledgement of receipt of the complaint within 10 business days.

During an interview with the Administrator regarding the Complaints policy, he indicated that the home had not followed their own policy in regards to the complaint submitted in December 2015 by Resident #001's POA.

The home's current Complaints policy #750.43 (effective November 2014) provided to the Inspector, indicated on page 2 of 3, under the section Operational Procedure, that:

2) The manager will initiate an investigation and respond to the complainant within 10 business days of the receipt of the complaint. Where the complaint alleges harm or risk to one or more residents, the investigation shall be commenced immediately.

3) For complaints which cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution and a follow-up response. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes:
-the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
-the final resolution, if any
-every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant
-any response made by the complainant

Upon review of the home's complaints record, three official written complaints had been

submitted by Resident #001's POA, using the Compliment/Complaint Form #750.43, which were found in the home's complaints binder, kept in the home's Administrative Assistant's office.

Complaint #1 - specific date in October 2015: concern related to staff creating obstacles to Resident #001's independence
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any and every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant were not documented

Complaint #2 - specific date in October 2015: concern related to how Resident #001 is dressed at night time
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any and every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant were not documented.

Complaint #3 - specific date in October 2015: related to staff using a wheelchair with a seatlbelt to restrain Resident #001
- the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any and every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant were not documented

During an interview with Program Manager #102 he indicated that he had conducted an investigation of the complaints stated above, but had not documented dates of the action, and any follow-up action, the final resolution and every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant. He further added that a meeting had taken place but as he had not taken notes he was unable to provide evidence regarding final resolution and dates when he had responded to the complainant. [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstance and ensure that a documented record is kept in the home that includes:
-the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
-the final resolution, if any
-every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant
-any response made by the complainant, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class.

Upon review of Resident #001's health record, it was documented that this resident had dementia with moderate to severe cognitive impairment. On the most recent assessment (a specific date in February 2016), it was documented that a trunk restraint was used daily to physically restrain Resident #001. It was also noted that the Resident was able to walk on his/her own with close supervision but due to unsteady gait, the resident was in a wheelchair with a front closure lapbelt for safety, when up.

Upon review of the home's complaints record, two written complaints had been submitted by Resident #001's POA related to concerns about the seatbelt used by staff to physically restrain the resident:
-a specific date in October 2015
-a specific date in December 2015

The inspector observed Resident #001 wandering without mobility aids on the unit on March 2, 3 and 4, 2016. On March 4, 2016, when the Inspector observed Resident #001 in a wheelchair with a front closure seatbelt in place, the resident was asked if could unfasten the seatbelt in presence of PSW #105 and Program Manager #102, and the resident was physically and cognitively unable to remove the seatbelt.

A review of the physician's orders was done by the Inspector, an original order dated a specific date in May 2015 and quarterly orders (last one dated: a specific date in January 2016) indicated that a lapbelt front closure and table top were prescribed for application when the resident was up in the Broda chair for safety.

During interview with PSW #110, he indicated that the resident wandered without mobility aids, but that a wheelchair with a seatbelt was used at meal time and that the brakes were applied to keep Resident #001 to prevent the resident from leaving the dining room as he/she had difficulty staying in one place.

Activity Coordinator #115 indicated that staff placed Resident #001 in the wheelchair with a seat belt on and applied the brakes on, at meal time to keep the resident at the table in the dining room. She added that over the course of the day, when the resident was aggressive or agitated the staff would use the wheelchair and seatbelt to prevent the resident from grabbing at other residents.

During an interview with RPN #108, she indicated that there was no order for a seatbelt when in wheelchair, that the only order available was for a lapbelt and table top when in a Broda Chair. She confirmed that a Broda chair and a wheelchair were different mobility aids.

In a progress note dated a specific date in August 2015, it was indicated that the resident would be returning to the home from hospital and that the Occupational Therapist from hospital stated that the resident was able to weight bear as tolerated, therefore would require a wheelchair that the resident would be able to self propel. The note further indicated that a specific wheelchair was provided with a specific seat cushion and a 4-point seat belt.

RN #104 indicated that staff used the Broda chair with the lapbelt and table top for Resident #001 post fracture of a specific area, and that the order was not updated when a wheelchair was assigned several months ago. She indicated that it was the home's expectation that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class, and that in this case, the order had not been revised when the Broda chair ceased to be used, therefore there was no order for the seatbelt used when the resident was in the wheelchair. [s. 110. (2) 1.]

2. The licensee failed to ensure that a consent is documented for every use of a physical device to restrain a resident under section 31 of the Act.

The inspector observed Resident #001 wandering without mobility aids on the unit on March 2, 3 and 4, 2016. On March 4, 2016, the Inspector observed Resident #001 in a wheelchair with a front closure seatbelt in place, when asked if could unfasten the seatbelt, in the presence of PSW #105 and Program Manager #102, the resident was physically and cognitively unable to remove the seatbelt.

In a progress note dated a specific date in February 2016, it was indicated that the previous day, the POA, both Program Managers and RN #104 met to review Resident #001's care plan. A note indicated that the POA's wish was to allow the resident to ambulate on his/her own, and with one or two staff when the resident was tired, and that the POA was aware of the high risk for falls and injury. The note further indicated that the POA's request and wishes would be addressed with the multidisciplinary team.

A review of Resident #001's health record indicated that the resident's Power of Attorney (POA) had signed a consent on a specific date in May 2015 for the use of a lapbelt front

closure and a table top when the resident was up in a Broda chair for safety. An updated consent was not found.

During an interview with RN #104, she indicated that it was the home's expectation that a consent by POA be signed for every physical device used to restrain a resident. She confirmed that a lapbelt and table top had not been used to restrain Resident #001 in a Broda chair for several months and was replaced with a seatbelt in a wheelchair. She further indicated that the seatbelt physical restraint would be reviewed with the POA. [s. 110. (7) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff apply physical devices that have been ordered or approved by a physician or registered nurse in the extended class and ensure that a consent is documented for every use of a physical device to restrain Resident #001, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care during meal time to Resident #001.

Resident #001's Power of Attorney (POA) reported that casual and part-time staff did not

seem to know what the Resident's food likes and dislikes were, what food to serve the resident and what type of assistance the resident required at meal time.

In a review of the most recent plan of care, it was indicated that Resident #001 continued to receive a pre-selected menu for a regular diet, regular texture, regular thin fluids, received fortified mashed potatoes at lunch and supper and fortified pudding at the evening snack time to support poor intake.

On Wednesday, March 2, 2016, the Inspector observed Resident #001's 2015/16 Winter Menu (Week 1) posted in the kitchen, by the servery on the bulletin board, in Bungalow 1.

Resident #001's posted pre-selected menu for Wednesday (2015/16 Winter Menu: Week 1) was documented as:
-Cream of Tomato Soup
-Havarti Cheese Sandwich on Marble Rye Bread
-Cucumber salad
-Mixed berries with sweetener

Alternate Choice
-Chicken à la King
-Patty Shell
-Carrots
-Jello Jewels

On Wednesday, March 2, 2016 from 1225 to 1300 the Inspector observed meal service in Bungalow 1 dining room. Meal options were observed as followed:
-Potato leek soup
-Beef pot pie
-New England blend vegetables
-Mango

Alternate Choice
-Salmon sandwich on whole wheat bread
-Carrot raisin salad
-Strawberry ice cream

Minced and pureed options were available, as well as mashed potato.

Resident #001 was walked without mobility aids by a staff member to a dining room table. At 1249 hours, RPN #108 was observed holding Resident #001's pre-selected menu (Week 1), and RN #104 requesting a cheese sandwich for Resident #001. FSA #112 indicated that there was no cheese sandwich, and a salmon sandwich was cut in four quarters and placed in a plate with carrot & raisin salad then brought by the RN to the resident.

PSW #109 and RPN #108 both indicated that they believed that Resident #001 was not able to make food selections, and that they were expected to follow the pre-selected menu completed by the resident's POA and the dietary staff, therefore on March 2, 2016 at lunch time, the alternate option (beef pot pie and New England vegetable blend) was not offered to Resident #001.

Following the meal service, the Food Services Attendant confirmed that week of February 29, 2016 was week 2 of the 4-week menu cycle, not week 1, as per the posted menus in the dining room.

During an interview with RN #104, she indicated that the resident's POA had pre-selected a meal for the resident for each day of the 4-week menu cycle, along with the Dietitian. In reviewing Resident #001's week 1 menu, she indicated that a cheese sandwich should have been prepared for the resident on March 2, 2016. She further indicated that Resident #001 could not make any food selection, and that sandwiches were provided, as finger food was easier for the resident to grab and eat independently. The RN later indicated that the team, including herself were following the posted Week 1 menus, while they should have been looking at Week 2 menus.

During an interview with the Food Services Supervisor (FSS) on March 4, 2016 she indicated that she had met with the resident's POA to review each meal of the 4-week cycle. The POA pre-selected some meals (in red on the resident's pre-selected menu) and on other days when no pre-selection was made, staff were expected to offer the two meal options to the resident. She indicated that the Food Services Attendants were responsible for replacing the weekly menu each Sunday evening and the daily menu every evening after supper but due to new hired staff, this was missed. She further indicated that the resident's pre-selected menu did not provide clear direction to staff, as it was not clear that staff needed to continue to offer 2 options on days where no pre-selected menu was identified in red, for example on Wednesday, March 2 at lunch time, staff were expected to offer Resident #001 both meal options:

-a salmon sandwich on whole wheat bread, carrot raisin salad; and
-beef pot pie and new England Blend vegetables. [s. 6. (1) (c)]

Issued on this 11th day of March, 2016

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

Original report signed by the inspector.