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

Division des foyers de soins de longue durée
Inspection de soins 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
Aug 4, 2016	2016_286547_0017	016128-16	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

LISA KLUKE (547)

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): June 27,28,29,July 7, 14 and 15, 2016

The purpose of this inspection was related to a complaint regarding the provision of care and provision of medications to resident #001 in the home, as well as the home's management of a complaint.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers(PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a Program Manager, an Administrative Assistant (AA) and the Administrator.
In addition the inspector reviewed: resident health care records, documents related to the home's investigations into a specified written complaint reported to the home, policies related to complaints, MediSystem Pharmacy, Assessment Skin, Pain Management, Pain Assessment and the inspector observed aspects of resident care and interactions with staff.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's pain and skin care needs changed.

Resident #001 was admitted to the home four years ago with several medical diagnoses including a neurological disease, a bone disease and circulatory issues. The resident's care plan identified the resident as risk for pressure ulcers related to immobility since a specified date in September 2015. Resident #001 was ordered a specified foot device in December 2015 for inward turning of a foot. The resident's care plan indicated that the foot device was to be applied daily when getting into his/her wheelchair and removed at night once in bed by PSW staff. Pain has not been identified as diagnosis for this resident's plan of care. Resident #001's annual care conference held on a specified date in March 2016 indicated that the resident was considered a risk for skin related to immobility and that the resident's skin was intact and in good condition.

Inspector #547 reviewed the resident's progress notes and the MDS monitoring and observations bath records from specified dates in March -April, 2016 that identified the following related to resident #001 experiencing pain and alteration of skin integrity:

On a specified date in March 2016, resident #001's son requested pain medication to be provided to the resident as complained of pain/discomfort to a specified foot. Analgesic was provided to resident #001 with good effect. The MDS monitoring and Observation record-Bath Record indicated the resident had a shower on this same date and no skin issues or concerns identified. This form is utilized by PSW staff to evaluate resident's skin from head to toe and to indicate part of the body that is affected. No bath /shower was identified three days after this specified date and skin was identified to remain intact on both assessments conducted six and ten days later.

On days twelve, thirteen and fourteen after the initial complaint above, the resident reported this specified foot was painful and requested pain medication. Analgesic was provided to resident #001 with good effect on each day.

The MDS monitoring and Observation record-Bath Record indicated the resident had a shower on the fourteenth day as well and that his/her skin remained intact.

On day fifteen after the initial complaint of pain, resident complained of pain to this identified foot and notes indicated " foot to be ++ tilt and twisted this am more than

normal". Analgesic was provided to resident #001 with minimal effect. No further assessment of the resident's foot was identified for the remainder of this day.

On day sixteen after the initial complaint of pain, resident was noted to be more confused than usual and complained of specified foot pain. Analgesic was provided to resident #001 with good effect.

On day seventeen after the initial complaint of pain, RN #112 documented that a PSW reported dried blood was noted on resident #001's bed sheets. RN #112 assessed an opening underneath the resident's specified foot from a pre-existing corn/callus area right after lunch and cleansed the open area and covered it with an absorbent dressing. The resident complained of pain to this same foot. Analgesic was then provided to resident #001 with good effect.

On this same date, resident #001 was found unresponsive four hours later and vital signs indicated the following: Temperature of 38.1, Blood Pressure of 189/108, pulse of 107 and respiratory rate of 24. Analgesic was provided to the resident at this time. No effect noted for this analgesic provided to the resident was on file.

On day eighteen after the original complaint of pain, resident #001 complained that his/her whole body was aching and analgesic was provided to the resident with good effect.

On day nineteen after the original complaint, resident #001 complained of the same foot /leg was in pain. Analgesic was provided to the resident. No effect noted for this anagelsic provided to the resident was on file.

On day twenty, resident #001 complained of this same foot pain. Analgesic was provided to the resident with good effect.

On day twenty one, resident #001 complained of bilateral leg pain. Analgesic was provided to the resident. No effect noted for this analgesic provided to the resident was on file.

On a specified date, twenty two days after the initial complaint of pain and seven days after the resident's skin opened to this same foot, RPN #101 indicated a wound assessment was completed for resident #001. A PSW reported a blackened area to the resident's specified foot was noted during morning care. RPN #101 noted the lateral

aspect of the resident's foot near the toes had migrated to the centre with blackened foul smelling stage x wound 6cmx2.5cm with sanguinous drainage and tunnelling under surface. Resident #001's physician was made aware and orders received to complete dressings as per orders every other day and as required.

No further documented showers/baths were provided to the resident after a specified date in April, 2016 after the initial complaint of pain, ten days prior to noting the development of stage X ulcer. PSWs are responsible to complete a head to toe skin assessment and report any alterations to the registered nursing staff.

Two days after the stage X ulcer was discovered, resident #001 was admitted to the hospital for assessment and treatment of infected foot ulcer.

No pain assessments of the resident's foot was located in resident #001 health care records until the stage X ulcer was discovered and identified on the Wound Assessment Tool.

PSW #103 indicated to the Inspector that resident #001 preferred bed baths and that they are to complete the MDS monitoring and Observation record-Bath records twice a week for every resident when baths are offered. Resident #001 received complete bed baths and PSW #103 indicated that they are responsible to wash their entire body including their feet. PSW #103 further indicated that PSWs apply the resident's foot device when the resident is up in his/her wheelchair daily. PSW #103 could not recall noting any altered skin to the resident's specified foot during this period of time between months of March to April, 2016.

PSW #104 indicated to the Inspector that resident #001 preferred showers and that they look at the resident's skin at that time, and complete the MDS monitoring and Observation record- Bath record at the end of their shift. PSW #104 indicated if they notice any skin issues such as redness, open areas, scratches and bruises that they need to report this to the registered nursing staff on duty. PSW #104 further indicated that PSWs remove the resident's foot device in the evening when the resident gets into bed. PSW #104 also could not recall noting any skin issues on resident #001's foot during this period of time between months March to April, 2016.

RPN #101 indicated that she was informed by a PSW on this specified date in April, 2016 to assess the resident's foot, as it was noted to have a blackened area on the bottom of the foot. RPN #101 indicated that this was the first time she was informed of

the resident's altered skin integrity to this foot.

RN #100 indicated to the Inspector that resident #001 was complaining of this foot pain almost daily and that the registered staff and PSW staff assumed this pain was related to the foot device in place to assist in positioning of the resident's foot. RN #100 indicated that she could not locate any pain assessment on file for this resident related to foot pain that is required for repeated pain medication being provided to the resident for the same area. RN #100 further indicated that skin assessments of the resident's foot related to the corn/callus or the open area that was assessed on a specified date in April, 2016 were also not located in the resident's records as required for any skin alteration.

RN #112 indicated to the Inspector that she had completed the resident's dressing on this specified date in April, 2016 when the PSW reported to her that the resident had dried blood noted on the resident's sheets. RN #112 did assess the resident and noted an open area to a specified foot and applied a dressing. RN #112 indicated that she should have completed a wound assessment tool and placed in the resident's MAR, but that she must have forgotten. RN #112 also indicated that she did not update the resident's plan of care and make any adjustments to interventions related to this skin wound.

Program Manager #110 indicated to the inspector on June 29, 2016 that the registered nursing staff in the home did not follow the home's policy and procedure titled " Assessment Skin" regarding resident #001's foot when the resident's foot skin was noted to have broken down integrity with corn/callus development, as well as when this corn/callus area opened on a specified date in April, 2016 as no wound assessment tool was conducted. Program Manager #110 further indicated that the resident had also been complaining of pain to this foot for at least a week prior to noting the open area on a specified date in April, 2016 and that a clinical assessment of both pain and skin should have been completed so that a treatment plan would have been developed and methods in place to prevent pressure or off-loading to the resident's foot.

In summary, on a specified date in April, 2016 resident #001 was assessed for an opening on a specified foot. On a specified date in March 2016 and then almost daily for a thirteen day period, resident #001 complained of foot pain. The resident health care records and staff interviews indicated that resident #001 was not reassessed and the plan of care was not reviewed and revised in regards to pain management or skin breakdown until seven days after the initial assessment of this foot, at which time resident #001 had developed a stage X ulcer sized 6cmX2.5cm and required

hospitalization for eight days for infection to this area. Resident #001 continues to have stage X ulcer at the time of this inspection.

Inspector #547 noted that a compliance order was left in the home in March 2015 with regards to non-compliance related to management of altered skin integrity.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Assessment Skin" policy and procedure instituted in the home related to skin assessments was complied with for resident #001.

In accordance with O.Reg.79/10,s.30.(1)1. general requirements identifies that every licensee of a Long-Term care home shall ensure that policies and procedures with respect to the organized Skin and Wound care program that provides for methods to reduce risk and monitor outcomes.

The home's policy titled "Assessment Skin" #315.12 last reviewed June 2012 provided to the inspector from Program Manager #110 indicated that " residents who are at risk for altered skin integrity shall have a skin examination conducted as the procedure

necessary for the completion of the skin and wound assessment tool ". The procedure indicated " for residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, complete the Wound Assessment Tool upon development or identification of a wound and at least weekly, or as per their treatment order, until healed ". The procedure further indicated to " document observations and identify interventions in the plan of care".

Resident #001's health care records were reviewed and it was indicated in the progress notes on a specified date in April, 2016 that the PSW reported dried blood on the resident's bed sheets was noted. RN #112 assessed the resident and indicated the bloody drainage came from underneath resident #001's foot. In reviewing the health care records, no wound assessment tool was completed by any staff member as per the home's policy. No orders for skin treatment or any communication to physician or wound care specialist, or plan of care related to altered skin integrity related to an opened area under the resident's foot until another specified date in April, seven days after the initial assessment when the PSW reported to registered nursing staff that the resident had blackened area under a specific foot. Resident #001 developed an infected stage X ulcer underneath the resident's foot and was hospitalized for eight days.

RN #100 indicated to the Inspector that a pain assessment should have been completed and on file for resident #001 who was noted to have complained almost daily related to the resident's left foot for a fourteen day period between March and April, 2016. RN #100 further indicated that this pain assessment would have led the registered nursing staff to an assessment of the resident's foot, that would have brought any skin issues to their attention, and thus would have completed a skin assessment tool as the corn/callus may have been causing the initial pain and discomfort. RN #100 further indicated that both these assessments were required as per the home's policies and procedures.

Program Manager #110 indicated to the Inspector on June 29, 2016 that the registered nursing staff in the home did not follow the home's policy and procedure regarding resident #001 when the resident's left foot skin was noted to have broken down skin integrity with corn/callus or when it opened on a specified date in April 2016 as no Wound Assessment Tool was completed, no treatment plan was initiated and the plan of care was not updated for this resident. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's "Pain Assessment" policy and procedure instituted in the home related to pain management was complied with for resident #001.

In accordance with O.Reg.79/10, s.30.(1) 1.general requirements identifies that every licensee of a Long-Term care home shall ensure that policies and procedures with respect to the organized Pain management program that provides for methods to reduce risk and monitor outcomes.

The home provided the inspector with the policy and procedure " Pain Assessment" # 315.18 last revised January 2014 indicated the following administrative practice: " The pain management plan of care shall be implemented if there is a change in the resident status or if pain control is not managed. a) for pain not managed requiring additional ongoing assessment staff will use the Ottawa Pain and Symptom Assessment Record".

RN #100 indicated to the Inspector that a pain assessment should have been completed and on file for resident #001 who was noted to have complained almost daily related to the resident's foot for a fourteen day period between March and April 2016. RN #100 further indicated that this pain assessment would have led the registered nursing staff to an assessment of the resident's foot, that would have brought any skin issues to their attention, and thus would have completed a skin assessment tool as the corn/callus may have been causing the initial pain and discomfort. RN #100 further indicated that both these assessments were required as per the home's policies and procedures.

Upon review of the resident's health care records with RN #100, it was noted that the resident did not have any pain assessments completed to date. Resident experienced pain daily for fourteen days to the same specified foot that did not have any pain assessment completed on file. The resident was diagnosed with a stage x ulcer to this foot on a specified date in April 2016 and sent to hospital two days later for an infected foot ulcer.

Program Manager #110 indicated to the inspector on June 29, 2016 that the resident had been complaining of pain to the left foot for at least a week prior to noting the open area on specified date in April 2016 and that if a clinical assessment tool had been completed, that a treatment plan would have been developed and methods to prevent pressure to the resident's foot and pain management would have been put in place. [s. 8. (1) (b)]

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 the policy and procedures related to skin assessments and pain assessments instituted or otherwise put in place is complied by registered nursing staff, to be implemented voluntarily.

WN #3: 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 a written complaint that was received concerning the care of a resident or the operation of the home shall be immediately forwarded to the Director.

Upon review of the home's complaint records, resident #001's Substitute Decision Maker (SDM) made a written complaint submitted in person on a Specified date in May 2016 during meeting held with the Administrator, the Social Worker and a Program Manager #110 regarding care and services provided to resident #001 in the home.

Program Manager #110 completed the Compliment/Complaint Form #750.43 eleven days after receiving the complaint by resident #001's SDM and the Administrator co-signed this form three days later. Program Manager #110 indicated to Inspector #547 that a copy of the complaint was forwarded to the Director under the Long-Term Care Home Act (LTCHA) but could not provide a date and time this was submitted. The Administrative Assistant for the Administrator was able to find a fax cover to indicate that the written complaint was sent forty five days after receiving this complaint. The Centralized Intake Assessment Triage Team (CIATT) with the Ministry of Health and Long term Care was able to confirm that this written complaint was actually faxed from the home to the Director seventeen days later, which was thirteen business days from the date the complaint was made to the home.

In discussion with the Administrator, he indicated that he was not aware that the written complaint had not been immediately forwarded to the Director as required 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 complaint received by the home regarding care of the resident or the operations of the home is forwarded to the Director under the (LTCHA) immediately, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

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

On a specified date in May 2016 Resident #001's Substitute Decision Maker (SDM) submitted a written complaint to the home related to care and services for resident #001 in a meeting held with the Administrator, Program manager #110 and the home's Social Worker. Program Manager #110 completed a Compliment/Complaint Form 750-43 related to this written complaint. This written complaint identified the following issues: Personal hygiene, personal care, meals, communication, medication and recent events related to pain and skin.

In reviewing the Compliment/Complaint Form, it was noted that the investigation results indicated " many of the complaints or concerns have already been addressed in previous complaints and a discussion at round table with no distinct request for follow-up at this time". Program Manager #110 was not able to identify completed investigations related to the items identified in this complaint. The Program Manager #110 further indicated that these items have not been resolved at this point in the SDM's perspective. Under the section " Final Resolution " on this form, it was noted that a discussion at the meeting on this specified date in May 2016 about interventions that could be implemented on the unit that are addressing his concerns about oversight/supervision. No response to the complainant has been made to date regarding concerns related to personal hygiene, personal care, communication, medication or to the events that occurred in April 2016 related to pain and skin.

During an interview with Program Manager #110, she indicated that she did not send any response to the complainant regarding plans, goals or interventions for care and services areas identified in the complaint made on the specified date in May 2016. Program Manager #110 provided the inspector copies of notes taken during the complaint meeting held on this date in May 2016, as well as the Compliment/ Complaint form which identified the following:

The perception of the satisfaction level of the originator of the concern/complaint/suggestion was marked as " satisfied ".

Inspector #547 interviewed the SDM on June 24, 2016 indicated that he brought these issues up initially to the home at the annual care conference on a specified date in March 2016 and then again at the meeting held on a specified date in May 2016 when he submitted a written complaint. The SDM indicated that he has not received any response, actions, information about education to staff or apology for issues he raised at the meeting in May 2016. The Administrator informed him that he would forward the written complaint to the Director under the LTCHA and that they would increase supervision on the units for some of the health care issues raised and concerns about the home. The complainant indicated he had no idea if any of this was done.

The Complaint/Compliment form further indicated that " the complainant has made managers aware of his concerns, and how he wanted to move forward. Interventions on the unit were discussed and addressed concerns about oversight/supervision."

The Administrator indicated to Inspector #547 that he met with the complainant in a face to face meeting held in May 2016 when the written complaint was submitted to him. The notes taken during this meeting indicated that the Administrator said that he would not respond to what was presented to them, as hearing many things, and that he would take all the information and submit as a formal complaint. The notes taken during this meeting did not address any actions taken or dates when they would be addressed. [s. 101. (1) 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 all written complaints made to the licensee or a staff member concerning care of resident #001 or the operations of the home is investigated, resolved where possible and response provided within ten business days of receipt of the complaint to the complainant and the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to resident #001 in accordance with the directions for use as specified by the prescriber.

Resident #001's health care records were reviewed and the medication reconciliation indicated the resident was prescribed several medications and vitamins. Resident #001 was provided with a blood thinner and an antibiotic from the emergency drug cupboard on the evening of a specified date in April 2016 as the resident's medications had not yet arrived from the pharmacy. The medication administration records then identified that resident #001 did not receive any other of the prescribed medications until the resident's medications arrived from the home's pharmacy one day later at approximately 1430 hours. The several drugs were not administered to resident #001 in accordance with directions for use as specified by the prescriber on the evening the resident returned from hospital or the next day shift.

-An antibiotic medication was borrowed from the home's emergency drug box on the evening the resident returned from hospital, however the emergency drug box records

and the resident's medication administration record indicated that the resident did not receive the morning dose the following day.

-Several vitamins were also ordered and not provided during this period of time.

Resident #001 returned from hospitalization on a specified date in April, 2016 at 1545 hours and was prescribed medication that was reconciled with the home's physician. Prescription medication orders were sent to the home's pharmacy at 1715 hours. Inspector #547 confirmed with the home's pharmacy service provider that they can provide medications on a 24-hour basis, seven days a week to the Long-Term care home.Operations Manager #106 with the home's pharmacy indicated that no call was received by the registered nursing staff to alert them of the orders being sent to them. Operations manager #103 further indicated that the pharmacy's policy and procedure with the home indicated that the registered nursing staff are suppose to call the after hours number provided to the home when prescribed orders are sent to them after the regular business hours of 1500 hours. Operations manager #106 confirmed that the prescribed medications ordered for the resident could have been delivered to the home in the evening the resident returned from the hospital.

2. Resident #001's was prescribed an antidyskinetic medication to be administered at 0800, 1400 and 2000 hours daily for management of a neurological disorder. The SDM indicated during an interview with the Inspector on July 7, 2016 that RPN #107 had provided a dose of this antidyskinetic medication to resident #001 on a specified date in July 2016 at 1230 hours instead of 1400 hours as prescribed. The SDM's concern is that this medication is being given too close together and this antidyskinetic medication is required to be administered to the resident at the specified prescribed times as directed by the resident's physician.

RPN #107 indicated during an interview on July 7, 2016 that she had provided resident #001 a dose of this antidyskinetic medication on a specified date in July 2016 at 1230 hours that was only due at 1400 hours and that there was no reason other than an error that this was provided at this time.

Program Managers #110 and #113 indicated to the inspector that the home's expectations for medication administration is that it should be provided at the prescribed times indicated for the resident and that only one hour before or after the prescribed time for the medication is considered acceptable and would need to be reviewed with registered nursing staff. [s. 131. (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 that resident #001 is administered medications in accordance with directions for use as specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received fingernail care, including the cutting of fingernails.

Resident #001's current plan of care reviewed on July 7, 2016 indicated the resident required fingernails to be trimmed and cleaned on bath days as identified on the Minimum Data Set (MDS) Monitoring and Observation Record-Bath Record. Resident #001's fingernails were documented to have been cleaned and trimmed on a specified date in June 2016 during a complete bed bath. It was further noted on the resident's annual care conference held on a specified date in March 2016 whereby the SDM identified a concern for resident #001's fingernail care.

Resident #001's fingernails were observed daily from a day after the bath identified above on a specified date in June 2016 for three days to be long and sharp with yellow/brown matter embedded under the resident's fingernails. The resident indicated to Inspector #547 on a specified date in June 2016 that he/she preferred to have shorter nails but the staff are busy.

On June 29, 2016 Inspector #547 interviewed PSW #108 working with the resident, indicated that the resident's hands are washed with daily morning care and with complete bed baths however he did not clean under the resident's nails as the resident finds this uncomfortable and he did not want to hurt the resident.

The Program Manager indicated that the home's expectations for daily morning care and complete bed baths is that the resident's would have their nails soaked in a basin if required to assist in the cleaning of the resident's nails and to use the home's equipment to clean and trim nails for every resident. The Program Manager further indicated that a review of how complete bed baths would be done with PSW's in the home on this specified unit now that this was identified. [s. 35. (2)]

Issued on this 5th day of August, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_286547_0017
Log No. / Registre no:	016128-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 4, 2016
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	PETER D. CLARK CENTRE 9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ted Cohen

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:

1. The licensee will implement a monitoring process to ensure that residents are reassessed and plans of care are reviewed and revised when residents' care needs change related to skin integrity and pain management.

2. All registered nursing staff shall review the home's pain assessment and skin assessment policy and procedures specifically related to assessment, intervention and documentation requirements.

3. Personal Support Workers shall receive training specific to altered skin integrity for residents, the home's documentation requirements and reporting of any resident skin related issues to registered nursing staff.

4. This plan shall identify the time line for completing these tasks and who will be responsible for completing each task.

The plan is to be submitted to Lisa Kluke by August 11, 2016 via fax to 613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's pain and skin care needs changed.

Resident #001 was admitted to the home four years ago with several medical diagnoses including a neurological disease, a bone disease and circulatory issues. The resident's care plan identified the resident as risk for pressure ulcers related to immobility since a specified date in September 2015. Resident #001 was ordered a specified foot device in December 2015 for inward turning of a foot. The resident's care plan indicated that the foot device was to be applied daily when getting into his/her wheelchair and removed at night once in bed by PSW staff. Pain has not been identified as diagnosis for this resident's plan of care. Resident #001's annual care conference held on a specified date in March 2016 indicated that the resident was considered a risk for skin related to immobility and that the resident's skin was intact and in good condition.

Inspector #547 reviewed the resident's progress notes and the MDS monitoring and observations bath records from specified dates in March -April, 2016 that identified the following related to resident #001 experiencing pain and alteration of skin integrity:

On a specified date in March 2016, resident #001's son requested pain medication to be provided to the resident as complained of pain/discomfort to a specified foot. Analgesic was provided to resident #001 with good effect. The MDS monitoring and Observation record-Bath Record indicated the resident had a shower on this same date and no skin issues or concerns identified. This form is utilized by PSW staff to evaluate resident's skin from head to toe and to indicate part of the body that is affected. No bath /shower was identified three days after this specified date and skin was identified to remain intact on both assessments conducted six and ten days later.

On days twelve, thirteen and fourteen after the initial complaint above, the resident reported this specified foot was painful and requested pain medication. Analgesic was provided to resident #001 with good effect on each day.

The MDS monitoring and Observation record-Bath Record indicated the resident had a shower on the fourteenth day as well and that his/her skin remained intact.

On day fifteen after the initial complaint of pain, resident complained of pain to this identified foot and notes indicated " foot to be ++ tilt and twisted this am more than normal". Analgesic was provided to resident #001 with minimal effect. No further assessment of the resident's foot was identified for the remainder of this day.

On day sixteen after the initial complaint of pain, resident was noted to be more confused than usual and complained of specified foot pain. Analgesic was provided to resident #001 with good effect.

On day seventeen after the initial complaint of pain, RN #112 documented that a PSW reported dried blood was noted on resident #001's bed sheets. RN #112 assessed an opening underneath the resident's specified foot from a pre-existing corn/callus area right after lunch and cleansed the open area and covered it with an absorbent dressing. The resident complained of pain to this same foot. Analgesic was then provided to resident #001 with good effect.

On this same date, resident #001 was found unresponsive four hours later and vital signs indicated the following: Temperature of 38.1, Blood Pressure of 189/108, pulse of 107 and respiratory rate of 24. Analgesic was provided to the resident at this time. No effect noted for this analgesic provided to the resident was on file.

On day eighteen after the original complaint of pain, resident #001 complained that his/her whole body was aching and analgesic was provided to the resident with good effect.

On day nineteen after the original complaint, resident #001 complained of the same foot /leg was in pain. Analgesic was provided to the resident. No effect noted for this anagelsic provided to the resident was on file.

On day twenty, resident #001 complained of this same foot pain. Analgesic was provided to the resident with good effect.

On day twenty one, resident #001 complained of bilateral leg pain. Analgesic was provided to the resident. No effect noted for this analgesic provided to the resident was on file.

On a specified date, twenty two days after the initial complaint of pain and seven

days after the resident's skin opened to this same foot, RPN #101 indicated a wound assessment was completed for resident #001. A PSW reported a blackened area to the resident's specified foot was noted during morning care. RPN #101 noted the lateral aspect of the resident's foot near the toes had migrated to the centre with blackened foul smelling stage x wound 6cmx2.5cm with sanguinous drainage and tunnelling under surface. Resident #001's physician was made aware and orders received to complete dressings as per orders every other day and as required.

No further documented showers/baths were provided to the resident after a specified date in April, 2016 after the initial complaint of pain, ten days prior to noting the development of stage X ulcer. PSWs are responsible to complete a head to toe skin assessment and report any alterations to the registered nursing staff.

Two days after the stage X ulcer was discovered, resident #001 was admitted to the hospital for assessment and treatment of infected foot ulcer.

No pain assessments of the resident's foot was located in resident #001 health care records until the stage X ulcer was discovered and identified on the Wound Assessment Tool.

PSW #103 indicated to the Inspector that resident #001 preferred bed baths and that they are to complete the MDS monitoring and Observation record-Bath records twice a week for every resident when baths are offered. Resident #001 received complete bed baths and PSW #103 indicated that they are responsible to wash their entire body including their feet. PSW #103 further indicated that PSWs apply the resident's foot device when the resident is up in his/her wheelchair daily. PSW #103 could not recall noting any altered skin to the resident's specified foot during this period of time between months of March to April, 2016.

PSW #104 indicated to the Inspector that resident #001 preferred showers and that they look at the resident's skin at that time, and complete the MDS monitoring and Observation record- Bath record at the end of their shift. PSW #104 indicated if they notice any skin issues such as redness, open areas, scratches and bruises that they need to report this to the registered nursing staff on duty. PSW #104 further indicated that PSWs remove the resident's foot device in the evening when the resident gets into bed. PSW #104 also could not

recall noting any skin issues on resident #001's foot during this period of time between months March to April, 2016.

RPN #101 indicated that she was informed by a PSW on this specified date in April, 2016 to assess the resident's foot, as it was noted to have a blackened area on the bottom of the foot. RPN #101 indicated that this was the first time she was informed of the resident's altered skin integrity to this foot.

RN #100 indicated to the Inspector that resident #001 was complaining of this foot pain almost daily and that the registered staff and PSW staff assumed this pain was related to the foot device in place to assist in positioning of the resident's foot. RN #100 indicated that she could not locate any pain assessment on file for this resident related to foot pain that is required for repeated pain medication being provided to the resident for the same area. RN #100 further indicated that skin assessments of the resident's foot related to the corn/callus or the open area that was assessed on a specified date in April, 2016 were also not located in the resident's records as required for any skin alteration.

RN #112 indicated to the Inspector that she had completed the resident's dressing on this specified date in April, 2016 when the PSW reported to her that the resident had dried blood noted on the resident's sheets. RN #112 did assess the resident and noted an open area to a specified foot and applied a dressing. RN #112 indicated that she should have completed a wound assessment tool and placed in the resident's MAR, but that she must have forgotten. RN #112 also indicated that she did not update the resident's plan of care and make any adjustments to interventions related to this skin wound.

Program Manager #110 indicated to the inspector on June 29, 2016 that the registered nursing staff in the home did not follow the home's policy and procedure titled " Assessment Skin" regarding resident #001's foot when the resident's foot skin was noted to have broken down integrity with corn/callus development, as well as when this corn/callus area opened on a specified date in April, 2016 as no wound assessment tool was conducted. Program Manager #110 further indicated that the resident had also been complaining of pain to this foot for at least a week prior to noting the open area on a specified date in April, 2016 and that a clinical assessment of both pain and skin should have been completed so that a treatment plan would have been developed and methods in place to prevent pressure or off-loading to the resident's foot.

In summary, on a specified date in April, 2016 resident #001 was assessed for an opening on a specified foot. On a specified date in March 2016 and then almost daily for a thirteen day period, resident #001 complained of foot pain. The resident health care records and staff interviews indicated that resident #001 was not reassessed and the plan of care was not reviewed and revised in regards to pain management or skin breakdown until seven days after the initial assessment of this foot, at which time resident #001 had developed a stage X ulcer sized 6cmX2.5cm and required hospitalization for eight days for infection to this area. Resident #001 continues to have stage X ulcer at the time of this inspection.

Inspector #547 noted that a compliance order was left in the home in March 2015 with regards to non-compliance related to management of altered skin integrity. (547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of August, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

Service Area Office /
Bureau régional de services : Ottawa Service Area Office