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
Oct 20, 2016	2016_384161_0044	028223-16	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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 29, 30, October 3, 2016.

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record, a Resident Unit Planner for LTC Facilities dated July - September 2016 and the home's INR Monitoring Protocol.

During the course of the inspection, the inspector(s) spoke with an identified resident's Substitute Decision Maker (SDM), the RAI Coordinator, Registered Practical Nurses (RPN) and Registered Nurses (RN).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition

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

Specifically failed to comply with the following:

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 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Resident #001 was admitted to the home in 2012 with multiple medical diagnoses. On an identified date in September 2016, the Director received a Complaint Information Report related to improper care of resident #001.

On September 29, 30, 2016 and October 3, 2016, Inspector #161 conducted an on-site inspection regarding the concerns brought forth by the SDM of resident #001.

Resident #001's health care record was reviewed. The resident's progress notes indicated that from early August 2016 until resident #001's admission to hospital, on an identified date in September 2016, resident #001 medical condition progressively declined. The resident's plan of care was regularly updated to reflect the resident's change in condition. This included increased assistance with activities of daily living, changes in medication which included antibiotic therapy and blood work. On an identified date in August 2016 the resident's attending MD ordered blood work to be done which included a complete blood count. It was expected that resident #001's blood work would be drawn by a laboratory technician on their next scheduled visit, which was the following day. The SDM made multiple enquiries to RN #103 regarding the blood work results of resident #001 whose blood work was to have been drawn on an identified date in August 2016. These enquiries led to the discovery two days later by RN #103, that the blood work scheduled for an identified date in August 2016 for resident #001 had not been drawn. On an identified date three days later in August 2016, the blood work originally ordered by the attending MD four days earlier, was subsequently drawn by the laboratory technician. The results of the resident's blood work were faxed from the laboratory to the home in the evening of the same day that the blood had been drawn. Resident #001's blood work results were then reviewed by both the evening RPN #105 and RN #110 who noted that some of the blood work results were outside normal limits. Together, they made the decision that the on-call physician would be notified the following day of resident #001's blood results. The following day, in August 2016, the on-call physician was notified by RN #103 of the resident's blood results and the decision was made to send resident #001 to hospital for further assessment and treatment.

On September 29, 2016 discussion held with RN #103 who indicated to Inspector #161 that the nurse who had originally processed the blood work requisition for an identified date in August 2016 had misfiled the lab requisition. Hence, when the laboratory technician came in on the following day to service the home, they were unaware of the blood work ordered for resident #001. RN #103 completed a new blood requisition for

resident #001 which was subsequently drawn by the lab on their next scheduled visit which was 4 days after the original MD order for blood work. According to the date and time stamp on resident #001's laboratory report, the resident's blood work results were faxed to the home in the evening of the same day that the blood had been drawn.

On September 30, 2016 discussion held with RPN #105 who indicated to Inspector #161 that on the date that the blood work had been drawn in August 2016 she noticed resident #001's blood work results in the fax machine at approximately 2200 hours. She reviewed these results and contacted RN #110 who was the Charge Nurse that evening. RPN #105 indicated to Inspector #161 that she and RN #110 reviewed the blood results of resident #001 and decided that the resident was stable and that the on-call physician could be notified the following day by the day staff. RPN #105 made a notation in the Resident Unit Planner for LTC Facilities for the following identified date in August 2016, that directed the day staff to follow-up with resident #001's blood results received the previous evening.

According to resident #001's progress notes, the following morning, on the identified date at 1030 hours, RN #103 telephoned the on-call physician regarding the blood work results. The on-call physician ordered that resident #001 be transferred to the hospital with the agreement of the resident's SDM. Resident #001's SDM was notified of the physician's recommendation to send the resident to hospital. The SDM gave verbal consent and resident #001was transferred to hospital via ambulance, where the resident was admitted for further assessment and treatment. Resident #001 was discharged from hospital 11 days later, on an identified date in August 2016 and transferred back to the home.

In summary, the licensee failed to ensure that the staff involved in the care of resident #001 implemented the resident's plan of care related to the blood work that was to have been drawn on an identified date in August 2016; and failed to notify the on-call physician on the identified date in August 2016 of the resident's blood work results that were outside normal limits, so that the different aspects of care were not integrated, nor consistent with nor complemented each other.

Written Notification #1 related to LTCHA 2007 S.O. 2007, c.8, s.6(1)(c), s.6(7), s.6(9)(1), related to a previously identified resident's plan of care was issued on October 6, 2016 by Inspector #161 in Inspection Report #2015_384161_0043.

Written Notification #1 related to LTCHA 2007 S.O. 2007, c.8, s.6(1)(c) related to a

previously identified resident's plan of care was issued on July 21, 2016 by Inspector #211 in Inspection Report #2016_219211_0013.

Written Notification #2 related to LTCHA 2007 S.O. 2007, c.8, s.6(7) related to a previously identified resident's plan of care was issued on July 21, 2016 by Inspector #211 in Inspection Report #2016_219211_0013.

Written Notification #2 related to LTCHA 2007 S.O. 2007, c.8, s.6(7) related to a previously identified resident's plan of care was issued on August 16, 2016 by Inspector #161 in Inspection Report #2015_384161_0037.

Compliance Order #001 related to LTCHA 2007 S.O. 2007, c.8, s.6(10) related to a previously identified resident's plan of care was issued on August 4, 2016 by Inspector #547 in Inspection Report #2016_286547_0017 with a compliance date of November 30, 2016. [s. 6. (4) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.24. (1)2 in that the licensee did not immediately report an incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. .

On an identified date in April 2016 the attending physician of resident #001 prescribed a medication patch to be applied to the resident's left lateral ankle daily at 2000 hours and removed the following morning at 0800 hours. On an identified date in July 2016 the Substitute Decision Maker (SDM) of resident #001 observed the medication patch on the resident's chest that was dated five days earlier and brought this observation to the attention of RPN #114 who took immediate action to remove the medication patch from the resident's chest.

On September 20, 2016 Inspector #161 discussed this incident with RPN #114. She indicated that on an identified date in July 2016 the SDM of resident #001 had brought to her attention that he had observed a medication patch on the resident's chest and that it was dated five days earlier, on an identified date in July 2016. RPN #114 examined resident #001 and observed same on the resident's chest which RPN #114 subsequently removed.

Inspector #161 reviewed the medication administration record of resident #001 for July 2016 and noted that on the identified date in July 2016 at 0800 hours, there were no registered nursing staff initials that indicated that the medication patch had been removed that morning. On an identified date in July 2016 there was a progress note in the health care record of resident #001 that indicated that the resident's attending MD was informed that the medication patch had not been administered to resident #001 as prescribed.

The medication patch had not been administered to resident #001 as prescribed which placed the resident at risk of harm and thus, the incident should have been reported immediately to the Director. [s. 24. (1) 2.]

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.