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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 13, 2018	2018_682549_0009	017085-17, 020851-17, 024361-17, 024413-17, 026675-17, 002796-18	Critical Incident System

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 26, 27, 28, March 2, 5 , 2018

The following logs were inspected all related to falls : # 017085-17, 020851-17, 024361-17, 024413-17, 026675-17, 002796-18

During the course of the inspection, the inspector(s) spoke with a resident, Personal Support Workers (PSW), a Recreation Aide, Registered Practical Nurses (RPN), Registered Nurses (RN), a Physician, the Program Manager of Personal Care and the home's Administrator .

The inspector reviewed resident health care files, the licensee's Fall Prevention Program Policy, last reviewed April 2017 and observed the provision of care being provided to residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day following an incident that causes an injury to a resident for which the resident is taken to a hospital and resulted in a significant change in the resident's health condition.

1. A Critical Incident Report (CIR) was submitted by the licensee to the Ministry of Health and Long Term Care (MOHLTC) on a specific date in 2018 indicating that an incident that caused an injury to a resident for which the resident is taken to the hospital and which resulted in a significant change in the resident's health condition.

Resident #001 was admitted to the home on a specific date in 2017 with multiple diagnoses.

Inspector #549 reviewed resident #001's health care record between a specific date in 2017 and a specific date in 2018. The resident's progress notes indicated that the

resident had a fall on a specific date in 2017 while trying to transfer self from a wheelchair. The resident was transferred to the hospital for further assessment the same day. The resident returned back to the home on a specific date in 2017 with diagnosed injuries. The progress notes also indicated that the resident was transferred to hospital on a later specific date in 2017 and admitted and treated for a specific illness. Resident #001 returned back to the home on a specific date in 2018.

Inspector #549 was unable to locate a Critical Incident Report submitted by the licensee to the Director for resident #001 related to the incident on a specific date in 2017 when the resident was transferred to hospital due to an injury for which resulted in a significant change in the resident's health status.

On February 28, 2018, Inspector #549 interviewed the Program Manager of Personal Care (PMOPC) who stated that the Director was not informed of the incident on the specific date in 2017 for which resident #001 was transfer to hospital and which resulted in a significant change in the resident's health condition.

2. A CIR was submitted by the licensee to the MOHLTC on a specific date in 2017, indicating that an incident that caused an injury to resident #002 for which the resident is taken to the hospital and which resulted in a significant change in the resident's health condition.

Resident #002 was admitted to the home on a specific date in 2016 with multiple diagnoses.

Inspector #549 reviewed resident #002's health care record between two specific dates in 2017. The resident's progress notes indicated that the resident had a fall on a specific date in 2017. The resident was transferred to the hospital for further assessment. The progress notes also indicated that on a specific date in 2017 the hospital telephoned the home to inform them that the resident had sustained a fracture.

During an interview on February 28, 2018 the Program Manager of Personal Care stated to the inspector that the licensee was aware of resident #002's injuries on a specific date in 2017, however, the Director was not informed of the injuries to resident #002 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status until three business days later.

3. A CIR was submitted to the MOHLTC on a specific date in 2017, indicating that an

incident that caused an injury to resident #006 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

Resident #006 was admitted to the home on a specific date in 2016 with multiple diagnoses.

Inspector #549 reviewed resident #006's health care record between two specific dates in 2017. The progress notes indicated that on a specific date in 2017 resident #006 pushed a Personal Support Worker causing the resident to fall. On a specific date in 2017 a mobile x-ray was ordered by the physician. While waiting for the results of the x-ray the resident was sent to hospital for further assessment on a specific date in 2017. The resident returned back from hospital on a specific date in 2017, with a diagnosed fracture.

On February 28, 2018 during an interview with the inspector the Program Manager of Personal Care stated that the Director was not informed of the incident on a specific date in 2017 that caused an injury to resident #006 for which the resident was taken to hospital on a specific date in 2017 and which resulted in a significant change in the resident's health condition until three business days later.

As such, the licensee failed to ensure that the Director was informed no later than one business day following the incidents that caused injuries to resident #001, #002 and #006 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition. [s. 107. (3)]

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 Director is informed no later than one business day after an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital., to be implemented voluntarily.

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Issued on this 13th day of March, 2018

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

Original report signed by the inspector.