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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d’Ottawa
347 rue Preston bureau 420
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Sep 9, 2019	2019_617148_0024	012857-19, 012906-19, 014507-19	Complaint

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

AMANDA NIXON (148), JANET MCPARLAND (142)

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): August 13-16 and 20-21, 2019.

This complaint inspection included logs 012857-19, 012906-19 and 014507-19, related to a medication incident and the alleged abuse of an identified resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care (PMORC), Program Manager of Personal Care (PMOPC), Program Manager for Resident Care at Carleton Lodge, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the identified resident and family.

In addition the inspectors reviewed the identified resident's health care record and observed the resident, the resident's care environment and staff to resident interaction. Documents related to the licensee's investigation of alleged physical abuse were reviewed along with records related to the medication incident.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. (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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that sets out the planned care for the resident, specific to the use of adaptive clothing.

The plan of care for resident #001 described the need for total dressing assistance.

Inspector #148 observed video footage for a specified date, whereby resident #001 was provided with care, by PSW #119 and PSW #120. PSW #119 was observed to gather the resident's clothing and choose a non-adaptive undershirt with adaptive over shirt. The PSW was observed to attempt to dress resident #001, in the non-adaptive undershirt to which the resident physically and verbally responded to the care. After approximately one minute of attempts, the PSW ceased use of the non-adaptive undershirt and proceed with the adaptive over shirt.

In discussion with the PMORC, and later in discussion with the PMOPC, it was identified that adaptive clothing (open back clothing) was in place on the identified date and that at least three adaptive undershirts were available for use. It was reported that the use of

adaptive clothing was required related to the resident’s range of motion.

The plan of care for resident #001 did not include the planned care for the resident specific to the use of adaptive clothing. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

The plan of care for resident #001 described the resident as responsive to care. The plan of care directed staff to acknowledge the resident’s response, to provide comfort, support and reassurance and to ensure pain is under control.

Inspector #148 observed video footage for a specified date, whereby resident #001 was provided with care, by PSW #119 and PSW #120. PSW staff members were observed to provide repositioning and continence care, without implementing the plan of care related to the resident's responsiveness to care; the resident was observed to be responsive to care.

On the specified date, the care set out in the plan of care was not provided to resident #001, as specified by the plan. [s. 6. (7)]

3. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective.

Inspector #148 observed video footage for a specified date, whereby resident #001 was provided with care. The resident was observed to become responsive when staff provided care. PSW #104 and #105, who were providing the care, were observed to provide comfort and reassurance. The PSWs discussed that pain may be a contributing factor to the resident’s response to care; no further action was taken. The care proceeded with resident #001, whereby the resident continued to respond to the care provided.

On the specified date, resident #001 was not reassessed and the plan of care was not reviewed when the care set out in the plan was not effective. [s. 6. (10) (c)]

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. 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 a drug was administered to resident #001 in accordance with directions for use specified by the prescriber.

Resident #001 had a physician order to receive an identified medication every six months.

In review of resident #001’s progress notes and the electronic medication administration record (eMAR) for an identified month, it was noted that the resident was administered the medication on two consecutive days.

In an interview with Inspector #142, RPN #123 confirmed that they administered the medication on a specified date, as it was scheduled in the eMAR for administration on that day. During an interview with Inspector #142, RPN #109 indicated that on a specified date, when administering resident #001’s medications, the eMAR indicated that the resident was scheduled for administration of the identified medication. RPN #109 confirmed that the medication was administered on the specified day.

In an interview with the DOC, they indicated that during the investigation into the medication incident, it was determined that when the Licensee implemented the eMAR system two different dates for the administration of the medication were created.

The licensee failed to ensure that resident #001 was administered a medication in accordance with the directions specified by the prescriber. [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 drugs are administered in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 19th day of September, 2019

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), JANET MCPARLAND (142)
Inspection No. / No de l'inspection :	2019_617148_0024
Log No. / No de registre :	012857-19, 012906-19, 014507-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 9, 2019
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
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 :	Shelley Kuiack

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

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 must be compliant with LTCHA, 2007, s.6

Specifically the licensee shall:
a) Ensure that the plan of care for resident #001 is reassessed as it relates to the provision of care and the resident's response to such care. The reassessment is to include, at minimum, an assessment of pain;
b) Revise the plan of care for resident #001 to ensure that effective interventions are in place to diminish the resident's responses to care;
c) Ensure interventions are in place to mitigate the risk of harm to resident #001 during the provision of care; and
d) Ensure that care is provided to resident #001 as specified by the revised plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the care set out in the plan was not effective.

Specifically, the licensee did not ensure that the plan of care for resident #001 was reassessed on a specified date, when interventions in place were not effective during the provision of care. In addition, on subsequent date, staff providing care to resident #001 did not provide care as set out by the plan of care.

The plan of care for resident #001 described the resident as responsive to care. The plan of care directed staff to acknowledge the resident's response, to provide comfort, support and reassurance and to ensure pain is under control.

Inspector #148 observed video footage for a specified date, whereby resident #001 was provided with care. The resident was observed to become responsive when staff provided care. PSW #104 and #105, who were providing the care, were observed to provide comfort and reassurance. The PSWs discussed that pain may be a contributing factor to the resident's response to care; no further action was taken. The care proceeded with resident #001, whereby the resident continued to respond to the care provided.

On the specified date, resident #001 was not reassessed and the plan of care was not reviewed when the care set out in the plan was not effective. [s. 6. (10) (c)]

Inspector #148 observed video footage for a specified date, whereby resident #001 was provided with care, by PSW #119 and PSW #120. PSW staff members were observed to provide repositioning and continence care, without implementing the plan of care related to the resident's responsiveness to care; the resident was observed to be responsive to care.

On the specified date, the care set out in the plan of care was not provided to resident #001, as specified by the plan. [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual risk of harm to resident #001. The scope of the issue was a level 1, with the compliance history a level 3 as non-compliance with this section of the LTCHA, 2007 has been issued as follows:
- Written Notification issued July 19, 2019 (2019_593573_0018)
- Voluntary Plan of Correction issued January 15, 2019 (2019_559142_0016)
- Voluntary Plan of Correction issued November 8, 2018 (2018_730593_0015)
- Compliance Order issued May 23, 2018 (2018_583117_0002)
- Written Notification issued February 5, 2018 (2018_708548_0027)
- Voluntary Plan of Correction issued November 21, 2017 (2017_617148_0028)
- Written Notification issued September 17, 2017 (2017_582548_0017)

- Voluntary Plan of Correction issued August 25, 2017 (2017_582548_0015)
- Voluntary Plan of Correction issued March 28, 2017 (2017_584161_0004)
- Voluntary Plan of Correction issued March 15, 2017 (2017_582548_0031)
- Written Notification issued October 2016 (2016_384161_0043)

(148)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 09, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of September, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

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