Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 30, 2019	2019_785732_0040	018149-19, 021264-19, 021891-19, 021903-19, 022561-19	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

EMILY BROOKS (732), LYNE DUCHESNE (117)

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): December 16 - 20, 2019

The following logs were completed during this Critical Incident System inspection:

Log #021903-19 (CIR M609-000038-19), log #022561-19 (CIR M609-000041-19), and log #018149-19 (CIR M609-000030-19) all related to falls.

Log #021891-19 (CIR M609-000037-19) related to alleged resident to resident abuse.

Log #021264-19 (CIR M609-000034-19) related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Services, Registered Nurses (RN), personal support workers (PSW), and residents.

The inspector(s) reviewed resident health care records and relevant policies; as well as observed the provision of care and services to residents, resident to resident interactions, and resident home care environments.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director. [Log # 021264-19]

A Critical Incident Report (CIR) related to an alleged incident of staff to resident abuse was reported to the Director. The home initiated and conducted an internal investigation into the alleged physical abuse of resident #003. As per reviewed documentation, the investigation was completed on a specified date. No evidence of abuse was identified. The Program Manager for Personal Care, who conducted the investigation, said to the inspector that they had not reported the results of the investigation to the Director. [s. 23. (2)]

2. The licensee has failed to ensure that the results of an alleged resident to resident physical abuse investigation undertaken under section 23(1)(a) of the Long-Term Care Home's Act (LTCHA), and every action taken under section 23(1)(b) of the LTCHA was reported to the Director

A CIR was submitted to the Director that described the alleged physical abuse of resident #005 by resident #006. It described that resident #005 and resident #006 were found in the lounge area by PSW #103, with blood coming out of an area of resident #005. Resident #005 was transferred to hospital. The CIR indicated there may be a plan to relocate one of the residents as they were currently both in the same living area.

The CIR was reviewed and did not include the results of the alleged abuse investigation, if resident #005 returned from hospital, final injury to resident #005, and if one of the residents was moved to a different room. In an interview with Program Manager of Personal Care #112, they acknowledged that they had not amended the CIR. (Log #021891-19) [s. 23. (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 results of alleged neglect or abuse investigations are reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #001 that sets out the planned care for the resident.

Resident #001 had an unwitnessed fall with transfer to hospital and significant change in status. Resident #001 returned from the hospital nine days later with diagnosis of fractured body part that was repaired.

Inspector #732 reviewed resident #001's current written plan of care, which was also the written plan of care in use after resident #001's return from hospital. The written plan of care indicated that resident #001 was independent with most transfers with mobility device, but required guidance and non-weight bearing support with mobility device and one staff with certain transfers. The written plan of care also indicated that resident #001 ambulated with a mobility device and that one staff to ensure using mobility device while ambulating to all areas on and off the unit, and in corridor independently.

Inspector reviewed resident #001's progress notes after return from hospital. A progress note written upon return from hospital indicated that resident #001 was two staff assist for transfer. Another progress note, dated two days later, indicated that resident #001 was not ambulating with a mobility device related to fracture. Current locomotion is a different type of mobility device with one staff to physical assist.

In an interview, RN #104 told Inspector #732 that resident #001 currently uses a specified mobility device with the assistance of one staff member to mobilize and that resident gets up to walk with the physiotherapy department. RN #104 also told Inspector #732 that resident #001 transfers with the assistance of one or two staff. In an interview with PSW #105, they told Inspector #732 that resident #001 mobilizes with a specified mobility device with the assistance of staff and is a two-person extensive transfer.

Therefore, the licensee has failed to ensure that the written plan of care for resident #001 set out the planned care for the resident. [s. 6. (1) (a)]

Issued on this 30th day of December, 2019

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

Original report signed by the inspector.