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


## Amended Public Copy/Copie modifiée 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 |
|---|---|---|---|
| Mar 16, 2021 | 2021_831211_0005 (A1) | 021694-20, 021742-20 | 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

Amended by JOELLE TAILLEFER (211) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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**

**This licensee inspection report has been revised to correct the title of a Registered Nursing Staff. The Complaint inspection # 2021_831211_0005 was completed on March 16, 2021.**

**A copy of the revised report is attached**

**Issued on this 16th day of March, 2021 (A1)**

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

**Original report signed by the inspector.**

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


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### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by JOELLE TAILLEFER (211) - (A1)

## Amended 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): January 12-14, 18, 21, 27-29 and February 1, 2021.**

**The following complaint intakes were completed in this inspection:**

**Logs # 021694-20 and # 021742-20 regarding resident care related to feeding and monitoring of specialized mattress.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care (PMRC), Program Manager of Personal Care, Registered Dietitian (RD), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs) and a family member.**

**During the course of the inspection, the inspector observed resident care, reviewed clinical health records and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Dining Observation**
**Reporting and Complaints**

**During the course of the original inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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. (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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in a resident's plan of care related to feeding technique was provided to the resident as specified in the plan.

The resident's care plan specified the feeding technique that needs to be provided during meals. The resident's progress notes indicated that a Registered Nursing Staff was informed by another staff member that the feeding technique specified in the resident's plan of care was not followed. The Program Manager of Personal Care stated that the staff member didn't follow the feeding technique as indicated in the resident's care plan.

Sources: The resident's progress notes and care plan, interview with the Program Manager of Personal Care. [s. 6. (7)]

***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 care set out in a resident's plan of care related to feeding is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**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.**
**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.**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
**4. Misuse or misappropriation of a resident's money.**
**5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure when a staff member who has reasonable grounds to suspect that improper care has occurred while feeding a resident, shall immediately report the suspicion and the information upon which it is based to the Director.

A resident's progress notes written on a specific date, indicated that a family member reported that the resident was put at risk while being fed by a staff member.

An email was sent by a Registered Nursing staff to the Program Manager of Personal Care and the Program Manager of Resident Care on the day that the family member reported the concern related to a staff member feeding the resident.

Interview with the Program Manager of Personal Care indicated that the Director was not informed immediately when the Registered Nursing Staff received the verbal complaint related to improper care while being fed by a staff member.

The licensee has failed to ensure when the Registered Nursing Staff who had reasonable grounds to suspect that a resident had received improper care during feeding was immediately reported the suspicion and the information to the Director.

Sources: A resident's progress notes. Interview with the Program Manager of Personal Care. [s. 24. (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 when a person who has reasonable grounds to suspect that improper care has occurred shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

**Issued on this 16th day of March, 2021 (A1)**

[redacted]

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

**Original report signed by the inspector.**