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

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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 2, 2021	2021_770178_0018	007882-21, 008326-21, 008709-21, 011018-21	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

SUSAN LUI (178)

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): August 12-13, 16-17, 19-20, 23-24, 2021.

The following intakes were completed in this critical incident inspection:
Log #007882-21 and Log #008326-21 were related to alleged neglect;
Log #008709-21 was related to a resident missing for less than three hours; and
Log #011018-21 was related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Managers Resident Care, Acting Manager of Recreation and Volunteer Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, residents, and families of residents.

During the course of this inspection the inspector observed the home environment and the provision of resident care, reviewed clinical health records, home investigative notes, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this 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 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

A resident who was at high risk for falls had specific directions which were to be followed for the resident's safety. These directions were not promptly followed on one day and the resident fell and was injured.

Sources: Progress notes and plan of care for a resident; interviews with RNs, an RPN, and PSWs. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

A resident was scheduled to receive a tub bath or shower twice weekly. PSW and registered nursing staff indicated that when baths or showers are provided or refused, this is documented on the resident's Bath Record. An RPN also indicated that if a resident refuses their bath or shower, the nurse should be informed and a progress note written. The resident's scheduled baths or showers, or refusal of same, were not documented on the Bath Record or in the progress notes for one week in 2021.

Sources: Unit Bath Schedule, a resident’s Bath Record and progress notes; interviews with a Program Manager Resident Care, an RPN, and PSWs. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the provision of the care set out in another resident's plan of care was documented.

A resident was scheduled to receive a tub bath or shower twice weekly. There was no documentation on the Bath Record or in the progress notes regarding the resident's scheduled baths or showers on eight occasions in three months of 2021.

Sources: Unit Bath Schedule, a resident's Bath Record and progress notes; interview with a PSW. [s. 6. (9) 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 that the care set out in the plan of care is provided as specified in the plan and documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, were kept closed and locked.

A resident exited the Bungalow dining room through an unlocked door into the courtyard area. The resident then exited the courtyard area through an unlocked gate and left the property. The resident was found within 15 minutes, unharmed, on a city street approximately 200 metres from the courtyard.

The home's internal investigation found that the electromagnetic locks (maglocks) in the Bungalows were not engaged for approximately 15 minutes on one day, and this is why the door from the dining room to the courtyard and the courtyard gate leading off the property were unlocked.

Sources: interview with Acting Manager of Recreation and Volunteer Services, and an RN; observations of the Bungalows and surrounding courtyard; review of a resident's clinical record. [s. 9. (1) 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 that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, are kept closed and locked, to be implemented voluntarily.

Issued on this 3rd day of September, 2021

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

Original report signed by the inspector.