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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
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Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1604_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Ottawa

Long-Term Care Home and City
Peter D. Clark Centre, Ottawa

Lead Inspector
Amanda Nixon (148)

Additional Inspector(s)
Cheryl Leach (719340)
Susan Lui (178)

Inspector Digital Signature

Digitally signed by Amanda Nixon
DN: cn=Amanda Nixon, o=LTC Inspections Branch, ou=MLTC, email=amanda.nixon@ontario.ca, c=CA
Date: 2022.06.03 11:45:22 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 21, May 5, 6, 9, 12, 13, 16-20, 2022

The following intake(s) were inspected:

- Intake 013925-21 Complaint related to the provision of the plan of care
- Intake 015038-21 Critical Incident Report (CIR) #M609-000045-21 related to a fall with injury and significant health change
- Intake 015640-21 CIR #M609-000049-21 related to resident to resident physical abuse
- Intake 016934-21 CIR #M609-000051-21 related to an unexpected death
- Intake 017138-21 CIR #M609-000052-21 related to resident to resident physical abuse
- Intake 018006-21 Complaint related to nursing support services
- Intake 018684-21 CIR #M609-000053-21 related to incompetent care
- Intake 019534-21Complaint related to lack of assessment and neglect
- Intake 008749-22 CIR #M609-000021-22 related to an unexpected death
- Intake 000927-22 Complaint related to skin care and changes to care

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION REPORTS RE CRITICAL INCIDENTS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 107 (3) 4

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Rationale and Summary
The Director was not informed of an incident with injury for a resident until seven days after the occurrence.

The Manager of Resident Care stated that the manager who would have been responsible to inform the Director, was not made aware of the incident until six days after the occurrence.

Sources: CIR# M609-000045-21, interview with Manager of Resident Care and the resident's progress notes.
[719340]

WRITTEN NOTIFICATION PLAN OF CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (9) 1

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident, as it relates to monitoring of a health condition.

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Rationale and Summary

A resident had an order for every shift monitoring of their health condition which was not documented in the Electronic Medication Administration Record (EMAR). The Manager of Resident Care and a Registered Practical Nurse confirmed that the monitoring was to be documented in the EMAR. The lack of documentation may lead to a possible risk to the resident of undiagnosed complications.

Sources:

The resident's EMAR, physician orders and progress notes.
[719340]