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
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 3, 2022
Inspection Number 2022_1604_0002
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)

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 11:49:33 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 22, 25-28, 2022

The following intake(s) were inspected:

- #007153-22 (Complaint) related to alleged staff to resident abuse
- #004371-22 (Complaint) related to alleged staff to resident abuse
- #006165-22 (CIR #M609-000015-22) related to alleged staff to resident abuse
- #004469-22 (CIR #M609-000009-22) related to alleged staff to resident abuse

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

- Prevention of Abuse and Neglect
- Responsive Behaviours

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
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

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

Non-compliance with: LTCHA, 2007 s.6(7)

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.

Rationale and Summary

A PSW failed to provide care to a resident as set out by the mood and behaviour plan of care. The PSW did not implement interventions as specified by the plan of care when the resident became responsive.

Sources:

A resident's plan of care and other digital information.

WRITTEN NOTIFICATION DUTY TO PROTECT

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

Non-compliance with: LTCHA, 2007 s.19

The licensee has failed to ensure that a resident was protected from abuse and neglect by a staff member.

Rationale and Summary

In accordance with O. Regulation 79/10, s. 2(1) "emotional abuse" means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident and "physical abuse" means, subject to subsection the use of physical force by anyone other than a resident that causes physical injury or pain.

In accordance with O. Regulation 79/10, s.5 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A PSW used physical force, threatening and intimidating gestures and remarks towards a resident when the resident began to exhibit responsive behaviours. The PSW subsequently left the resident alone, failing to provide the resident with required care.

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
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

The PSW's use of physical force, threatening and intimidating gestures and remarks may have escalated the resident's responsiveness. Such actions by the PSW increased the resident's risk of injury.

Sources:
Digital information