

**Original Public Report**

<b>Report Issue Date</b>	August 26, 2022		
<b>Inspection Number</b>	2022_1604_0004		
<b>Inspection Type</b>			
<input checked="" type="checkbox"/> Critical Incident System	<input checked="" type="checkbox"/> Complaint	<input type="checkbox"/> Follow-Up	<input type="checkbox"/> Director Order Follow-up
<input type="checkbox"/> Proactive Inspection	<input type="checkbox"/> SAO Initiated		<input type="checkbox"/> Post-occupancy
<input type="checkbox"/> Other	_____		
<b>Licensee</b>	City of Ottawa		
<b>Long-Term Care Home and City</b>	Peter D Clark, Nepean		
<b>Lead Inspector</b>	Karen Bunes 720483		
	<b>Inspector Digital Signature</b>		

**INSPECTION SUMMARY**

The inspection occurred on the following date(s): July 25, 26, 27, 28, 29, August 1, 2, 3, 4, 5, 8, 9, 2022

The following intake(s) were inspected:

- Intake: 013230-22 (Complaint) related to care delivery
- Intake: 012340-22 (Complaint) related to fluid texture and consistency
- Intake: 009576-22 (Complaint) related to infection prevention and control
- Intake: 014605-22 (Complaint) related to care delivery

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services

## INSPECTION RESULTS

### NON-COMPLIANCE REMEDIED DINING AND SNACK SERVICE

#### **NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)**

O. Reg. 246/22 s.79 (1) (4)

Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

#### **Rationale and Summary:**

A family member was provided thickened water to give to a resident that was prepared incorrectly resulting in a fluid consistency which was potentially dangerous to the resident. It was identified in the resident's plan of care the resident was to receive thickened fluids due to their health status. The resident did not receive the water provided as the family member noticed the consistency and alerted the staff.

At time of the inspection staff had received training on how to prepare thickened fluids. Education was provided by the Registered Dietician and will be reviewed on an annual basis. Additionally, signage providing measurements and instructions on how to prepare thickened fluids was posted in the servery.

#### **Sources:**

Interview with a Resident Care Manager, a Registered Dietician, a Food Service Attendant, and 2 Personal Support Workers.

**Date Remedy Implemented:** July 6, 2022 [720483]

### WRITTEN NOTIFICATION PERSONAL CARE

#### **NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s.36**

The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis

**Rationale and Summary:**

The resident's incontinent brief was not changed at the time directed in the resident's plan of care.

The resident was not positioned on the correct side as directed in the resident's plan of care. Registered staff and front-line staff confirmed the resident's plan of care includes specific time frames the resident's incontinent pad is to be changed and provides direction of how to position the resident. As a result, the resident did not receive personalized care on these two occasions.

**Sources:**

Interview with a Resident Care Manager, 1 Registered Nurse and 1 Registered Practical Nurse, 1 Personal Support Worker, a family member and the resident's clinical record.

[720483]