Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 29th 2023	
Inspection Number: 2023-1604-0005	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Ottawa	
Long Term Care Home and City: Peter D. Clark Centre, Ottawa	
Lead Inspector Erica McFadyen (740804)	**Inspector Digital Signature**
Additional Inspector(s) Karen Buness (720483)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17th-21st, 24th-28th and May 2nd, 2023

The following intake(s) were inspected:

- Intake: #00001430 - [CI: M609-000051-22]Fall of resident resulting in injury.
- Intake: #00002063 - [CI: M609-000047-22]Fall of resident resulting in injury.
- Intake: #00005509 - [CI: M609-000050-22]Fall of resident resulting in injury.
- Intake: #00009087 - M609-000052-22 Fall of resident resulting in injury.
- Intake: #00012956 - M609-000058-22 Fall of resident resulting in injury.
- Intake: #00014449 - IL-07658-OT - Complainant regarding resident plan of care, responsive behaviours, and care concerns
- Intake: #00014542 - M609-000060-22 - Fall of resident resulting in injury.
- Intake: #00014664 - IL-07738-AH/M609-000061-22 - Fall of resident resulting in injury.
- Intake: #00015435 - M609-000066-22 Resident to resident alleged physical abuse resulting in injury
- Intake: #00016648 - IL-08535-AH/M609-000074-22 Resident to resident alleged physical and verbal abuse.
- Intake: #00018588 - M609-000001-23 -Fall of resident resulting in injury.
- Intake: #00021818 - M609-000006-23: Alleged neglect of resident by staff.
- Intake: #00084474 - M609-000009-23 - Alleged resident to resident sexual abuse.

- Intake: #00085597 - IL-12087-OT -Complaint alleging that the home did not report resident to resident sexual abuse.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The Licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary
On a specified date resident #004 sustained a fall in their room. Following the fall, resident #004 was sent to the hospital where they were diagnosed with a specified injury. Resident #004 died in the hospital. Review of the falls plan of care for resident #004 stated that a specified intervention should be in place at all times. The Post Fall Assessment completed for resident #004 after their fall noted that resident #004 did not have a specified intervention in place at the time of the fall.

In interviews with RPN #109 and Program Manager of Resident Care (PMRC) #106 it was stated that resident #004 did not have this intervention in place at the time of the fall. In an interview with PMRC #106 it was noted the care plan for resident #004 was not followed at the time of the fall.

The impact of this noncompliance is that the falls plan of care for resident #004 was not being followed at the time when they sustained a fall which resulted in specified injuries and subsequent death.

Sources
Review of clinical record for resident #004, interview with RPN #106 and PMRC #106

[740804]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that their written policy for prevention of abuse and neglect was complied with.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure their written policy related to resident abuse and neglect is complied with. The licensee did not comply with their "Resident Abuse and Neglect Policy 750.65" while providing care to resident #005, #006, #007 and #008. Specifically, the policy states that "The Charge Nurse will immediately report the allegation to the Administrator/ Manager of Resident Care/ Manager On-Call, who will assess, based on the review of definition and decision tree, if it is a mandatory reporting to the Ministry" and "The Administrator/ Manager of Resident Care/ Manager On-Call must immediately notify: the Ottawa Police if it is believed that the incident constitutes a criminal offense and The Ministry of Long-Term Care"

Rationale and Summary

In the progress notes for resident #005 on a specified date it was documented by RN #113 that resident #006 was engaged in sexual contact with resident #005. During an interview with RN #113 it was stated that a manager was not notified of this interaction. During an interview with DOC #108 it was stated that by not informing a manager about the alleged resident to resident sexual abuse RN #113 did not comply with the licensee's abuse and neglect policy.

In the progress notes for resident #006 on a later specified date it was documented by RN #113 that resident #006 was found to be engaged in sexual contact with resident #005. In this note RN #113 states that DOC #108 was notified of this incident by phone. During an interview with RN #113 and RPN #112 it

was stated that DOC #108 directed RN #113 to not initiate the process laid out in the licensee's Resident Abuse and Neglect Policy. During an interview with DOC #108 it was stated that the information contained within the progress note was not the same information that was verbally communicated by RN #113, but that based on the information in the progress note that the procedure laid out in the Resident Abuse and Neglect Policy should have been initiated. During this interview DOC #108 stated that the Resident Abuse and Neglect Policy was not complied with. During an interview with Administrator #114 it was stated that the licensee's Resident Abuse and Neglect policy was not complied with.

The risk of the licensee not complying with their Abuse and Neglect policy is that allegations of abuse and neglect may not be appropriately and promptly addressed within the home.

Rationale and Summary

As documented in the progress notes, resident #007 started to display signs of a injury on a specified date. After receiving x-ray results this was noted to be as a result of a specified injury.

On a specified date RN #115 charted that it had been reported them that resident #007 and #008 had been observed to have a physical altercation five days earlier which may have resulted in resident #007's specified injury. In an interview with RN #115 it was stated that they did not inform the management team of the reported physical altercation between resident #007 and #008 when it was reported to them.

In an interview with DOC #116 it was stated that by not informing a manager of this alleged resident to resident physical abuse, RN #115 did not comply with the licensee's Resident Abuse and Neglect Policy.

The risk of the licensee not complying with their Abuse and Neglect policy is that allegations of abuse and neglect may not be appropriately and promptly addressed within the home.

Sources:
Clinical record for residents #005, #006, #007 and #008, interviews with RPN #112, RN #113, RN #115, DOC #108, DOC #116, and Administrator #114, review of the licensee's Resident Abuse and Neglect Policy

[740804]

WRITTEN NOTIFICATION: Responsive Behaviours

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NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 2.

Rationale and Summary

Personal Support Worker #102 and Registered Practical Nurse #103 stated that resident #001 has a history of responsive behaviours and have observed incidents involving co-residents. They also stated strategies are used to assist in preventing such incidents and the strategies are communicated by including them in the resident's care plan. RN #100 and Manager of Resident Care #106 confirmed the interventions should be included in the resident's care plan.

A review of resident #001's health record revealed that resident #001 was involved in multiple verbal and/or physical incidents with co-residents over a two month period. The resident's history of behavioural symptoms were included in the care plan but the care plan did not include strategies to prevent the responsive behaviours or minimize co-resident's reaction to these behaviours.

Failure to communicate the techniques and strategies to prevent, minimize or respond to responsive behaviours in the residents care plan put resident #001 at an increased risk of negative interactions with co-residents

Sources
Resident #001's clinical health record, observations and interviews with the Program Manager of Resident Care, a Registered Nurse, a Registered Practical Nurse and Personal Support Workers [720483]