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
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Original Public Report

Report Issue Date: August 18, 2023
Inspection Number: 2023-1604-0006
Inspection Type: Complaint Critical Incident System
Licensee: City of Ottawa
Long Term Care Home and City: Peter D. Clark Centre, Ottawa

Lead Inspector	**Inspector Digital Signature**
Karen Buness (720483)	

Additional Inspector(s) Kelly Boisclair-Buffam (000724) Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 3, 4, 8, 9, 10, 2023

The following intake(s) were inspected:
- Intake: #00020179 - Suspected staff to resident neglect
- Intake: #00085831- Improper care of a resident care resulting in a fall
- Intake: #00087300- Suspected staff to resident verbal abuse
- Intake: #00089742- Fall of resident resulting in a significant change in health status
- Intake: #00092125- Fall of resident resulting in a significant change in health status
- Intake: #00092410- Fall of resident resulting in a significant change in health status
- Intake: #00091751 - Complaint related to staff qualifications

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

Food, Nutrition and Hydration
Infection Prevention and Control
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 related to toileting set out in the plan of care was provided to the resident as specified in their plan.

Rationale and Summary
A resident was found on their bathroom floor on a specified date. The resident's plan of care indicated that they were at risk for falls and were to be a two person assist for toileting. The plan of care also indicated that the resident was not to be left unattended when on the toilet. The Resident Care Manager #100 and registered staff acknowledged that the resident was a two person assist and was not to be left alone on the toilet. The Resident Care Manager #100 investigated the incident and concluded the plan of care was not followed on the specific date.

As a result of not following the resident's specific plan of care , the resident fell to the floor when left unattended.

Sources:
Critical incident report submitted, interviews with staff , Homes' investigation notes, resident progress notes and plan of care.

[000724]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the residents has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
A Critical Incident System (CIS) report, related to improper or incompetent treatment of a resident that resulted in harm or a risk of harm, was submitted to the Director on a specified date.

The Resident Care Manager #100 acknowledged that incidents related to improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm, should be reported on time to the Director. Resident Care Manager #100 acknowledged that a call to the Action Line should have taken place.

Sources
Critical Incident report submitted, interview with Resident Care Manager #100.

[000724]