Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 12, 2023

Inspection Number: 2023-1604-0007

Inspection Type:
Complaint
Critical Incident

Licensee: City of Ottawa

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

Lead Inspector	**Inspector Digital Signature**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.10.12 13:33:13 -04'00'

Additional Inspector(s)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5, 6, 7, 8, 11, 12, 2023
The inspection occurred offsite on the following date(s): September 8, 2023

The following intake(s) were inspected:

- Intake: #00094304 - CI: M609-000032-23 - Alleged family to resident abuse.
- Intake: #00094424 - IL-16331-OT Complaint regarding care decisions for resident and resident care.
- Intake: #00094779 - IL-16499-OT Complaint regarding resident care.
- Intake: #00094951 - IL-16573-OT Complainant alleges breach of confidentiality for resident.
- Intake: #00095039 - CI: IL-16629-AH/M609-000033-23 Unwitnessed fall of resident causing injury and change in condition.

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

Resident Care and Support Services
Continence Care

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation of plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, 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. Specifically, the required hourly rounding for a resident was not documented.

Rationale and Summary
A resident had hourly rounding implemented as a safety and fall prevention measure, as written in the resident's plan of care, after a fall caused injury and a change in condition. The inspector reviewed the resident's Resident Safety/Comfort Rounding Sheets and identified missed entries for significant periods of time during the day shift were found on six separate dates. The inspector reviewed the resident's paper chart with a Personal Support Worker (PSW), no hourly rounding documentation could be determined on the identified dates. The PSW stated that hourly rounding of the resident must be documented by PSWs. The Manager of Resident Services stated that hourly rounding, if implemented as a fall safety measure, must be documented on the Resident Safety/Comfort Rounding Sheets.

Not ensuring hourly rounding was documented, for the resident, risks the resident's safety status not being clearly communicated to other staff members.

Sources:
Interviews with a PSW and the Manager of Resident Services;
The resident's medical record.

[740785]