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: January 16, 2024

Inspection Number: 2023-1604-0008

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**
Marko Punzalan (742406)	Marko Punzalan Digitally signed by Marko Punzalan Date: 2024.01.25 12:49:53 -05'00'

Additional Inspector(s)
Gabriella Kuilder (000726)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 20, 21, 27, 28, 2023 and January 2, 3, 4, 5, 2024

The following intake(s) were inspected:

- Intake: #00099589 – Complaint - Trust fund exceeding the limit.
- Intake: #00095897 -CIR #M609-000034-23 - Alleged physical abuse of resident.
- Intake: #00097668 – CIR #M609-000036-23 - Verbal abuse of resident to resident.
- Intake: #00098344 – CIR #M609-000038-23 - Fall resulting in an injury.

- Intake: #00098890 – CIR #M609-000039-23 – Improper care of a resident.
- Intake: #00099965 – CIR #M609-000042-23 – Resident to resident physical abuse.
- Intake: #00101590 – CIR #M609-000047-23 – Fall resulting in a significant change in health status.
- Intake: #00102041 – CIR #M609-000048-23- Alleged staff to resident physical 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
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

Duty of licensee to comply with plan

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to comply with FLTCA, 2021 s. 6 (7) related to ensuring that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary:

Resident experienced a change in condition increasing their safety risk requiring 1:1 staff observation to maintain the resident's safety. On a specified date, 1:1 observation was ordered by the attending physician.

During the review of the resident's health care records, it was reported the Personal Support Worker (PSW) left the resident unattended.

On a specified date, Personal Support Worker (PSW) was assigned 1:1 duties. Registered Practical Nurse (RPN) confirmed at the beginning of the evening shift they informed PSW of the resident's change in condition, safety concern, and direction not to leave the resident unattended at any time.

RPN reported PSW, was observed setting up the dining table, and not providing 1:1 support to resident. Re-instruction was provided by RPN to PSW regarding not leaving the resident unattended at any time. On a second occasion during the shift PSW left the resident unattended, and upon their return resident was found on the floor.

Failure to ensure that the care set out in the plan of care is provided to the resident as specified in the plan increases the risk of harm and safety to the resident.

Sources: Resident's health care records, interview with PSW and RPN [000726]

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)

Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee failed to protect resident on a specified date when a staff member witnessed physical abuse of a resident and did not report the incident as per policy until approximately 3 hours later.

Rationale and Summary:

A review of resident's healthcare records indicated, that on a specified date and time, a Personal Support Worker (PSW) witnessed a specific person slapping the resident. This was not immediately reported to the registered staff member.

Documents received via email from Registered Nurse (RN) confirmed the identified witnessed incident of slapping resident occurred on the specified time However, they did not become aware of this alleged incident until PSW reported it at a later time.

An interview with PSW confirmed the incident of slapping resident occurred on a specified time and was not reported until a later time.

An interview with RN confirmed that PSW did not immediately report the slapping of resident to the registered staff.

Failure to immediately report and intervene in a witnessed incident of physical abuse put the residents' health and safety at an increased risk for further abuse and harm.

Sources: Resident's health care records, interview with PSW and RN [742406]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to comply with FLTCA, 2021 s. 28 1 (1) regarding immediately reporting to the Director an alleged incident of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to resident.

Rationale and Summary:

On a specified time PSW was assigned 1:1 observation to resident. PSW left the resident unattended during this time and the resident sustained a fall.

A review of Critical Incident Report #M609-000039-23 indicated the incident was not immediately reported to the Director.

Registered Nurse (RN) reported the incident to the on-call manager on a specified time, however, the incident was not immediately reported to the Director.

Interview with Program Manager of Resident Care (PMORC) and Program Manager of Personal Care (PMOPC) confirmed the incident was not immediately reported to the Director.

Failure to immediately report improper or incompetent treatment or care to the Director could result in an increased risk of harm to a resident.

Sources: Resident's health care records, investigation notes, interview with PMORC, PMOPC and RN.
[000726]

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