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: March 19, 2024	
Inspection Number: 2024-1604-0001	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Peter D. Clark Centre, Ottawa	
Lead Inspector Shevon Thompson (000731)	**Inspector Digital Signature** Shevon M Thompson Digitally signed by Shevon M Thompson Date: 2024.04.16 08:59:11 -04'00'
Additional Inspector(s) Sarah Bradshaw (740814)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20, 21, 22, 23, 27, 28, and 29, 2024

The following intakes were inspected:

- Intake: #00104375 - Related to an incident of alleged neglect of a resident by staff.
- Intake: #00106590 - Related to an incident of alleged abuse of a residents by another resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident were kept aware of the contents of the resident's plan of care.

Rationale and Summary:
In a review of the resident's plan of care, the inspector noted the resident had a history of inappropriate behaviour towards a co-resident with a specific intervention. In a review of the resident's Kardex, the inspector noted the specific intervention was present. During a review of the investigation notes, in an e-mail from a registered staff to a Manager of Resident Care, it was noted that a registered staff

had reported that the specific intervention had not been followed.

In an interview with a staff, they were unable to confirm the specifics of the intervention. A registered staff confirmed, in an interview, that they were not aware of the specific intervention in the plan of care. Upon completion of the interview the registered staff reviewed the resident's plan of care and confirmed that the specific intervention was present in the plan of care. The Manager of Resident Care confirmed that staff on both units were expected to know the specific intervention that was in the resident's plan of care

Failure to ensure that the staff and others who provided direct care to the resident were kept aware of the contents of the resident's plan of care placed the resident at risk for harm.

Source: resident electronic health record and Kardex, the home's Investigation notes, Interview with PSW, RPN, and Manager of Resident care. [000731]

WRITTEN NOTIFICATION: IPAC -Routine Practices and Additional Precautions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure compliance with any standard issued by the Director with respect to infection prevention and control (IPAC).

Specifically, the licensee has failed to ensure compliance with section 9.1 (d) of the IPAC Standard for Long-Term Care Homes that Routine Practices and Additional Precautions were followed in the IPAC program and failed to ensure that at minimum Routine Practices included proper use of PPE, including appropriate selection, application, removal, and disposal, when a staff was toileting a resident that was on contact precautions.

Rationale and Summary:
In February 2024, the inspector observed contact Precautions and Routine Practices signage on the door to a resident's room. A staff was present in the room and confirmed that the resident was being toileted. The staff was noted to be wearing a mask but no gown.

The staff confirmed that the sign on the door of the resident's room indicated that the resident was on contact precautions which meant that Personal Protective Equipment (PPE), including gloves and gown, were to be worn when toileting the resident.

In an interview with a registered staff, they confirmed that if a resident was on contact precautions the staff were expected to wear gown, gloves, mask and eye protection if there was a possible exposure to splashes. In an interview with the IPAC Lead, they confirmed that staff were expected to wear gloves, gown and mask when toileting a resident that was on contact precaution.

Failure in the proper use of PPE, including appropriate selection and application placed the staff at an increased risk of contracting infectious pathogens and transmitting these infectious pathogens to other residents.

Source: observation of Additional Precautions signage on the door of a resident's room, Interview with staff and IPAC Lead, [000731]