Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 13, 2015	2015_225126_0005	O-001393-14, O-001602-15	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

Long-Term Care Home/Foyer de soins de longue durée

PETER D. CLARK CENTRE
9 MERIDIAN PLACE OTTAWA ON K2G 6P8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 27, 28, 29, February 11, 12, 13, 27 and March 3, 2015

During the course of this inspection, complaint Log # 001738-15 was included in CI Log # O-001602-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Manager of Resident Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, residents and family members.

During the course of the inspection, the inspector(s) reviewed the resident's health care record, reviewed the notes of an interview held between the Management Team and the nursing staff and observed care and services provided to residents. The following policies were reviewed: Skin and Wound Care Program and Skin and Wound Care: Skin integrity risk and assessment.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that Resident #02 received immediate treatment and interventions when exhibiting altered skin integrity.

On a specific date in January 2015 a critical incident related to Abuse/Neglect, staff to resident abuse was submitted to the Ministry of Health and Long Term Care. The description of the unusual occurrence indicated "Night shift brought to our attention resident has altered skin integrity.Resident was sent to hospital and passed away a specific date in February 2015.

On February 11, 2015, Inspector #126 initiated Critical Incident Inspection at the Home. The Administrator was informed of the purpose of the inspection. The Administrator indicated that a Critical Incident for Abuse/Neglect was submitted as they were not sure what happened. The conclusion of their investigation was a failure of communication between Personal Support Workers and the Registered Nursing staff.

Resident #02 health care record included several documents and the following were reviewed:

The " MDS Monitoring Observation Record-Bath Record", it is documented that a bed bath was given to Resident #02 on a specific day of January 2015 by Personal Support

Worker (PSW) S#106. On that day, S# 106 documented that Resident #02 had altered skin integrity.

On February 13, 2015, S# 106 was interviewed regarding the documentation of that specific day in January 2015. S# 106 indicated that " cavillon" cream was applied on Resident #02 altered skin integrity area area and that the nurse is usually informed. S# 106 could not remember which nurse was notified of Resident # 02's altered skin integrity. No documentation was found in the progress notes or in the wound assessment tool as per the home protocol requirement related to this observation.

The" basic care flow sheet" was reviewed for a period of 7 days in January 2015. It was noted that Resident #02 received care on a daily basis and observation of the altered skin integrity area should have occurred.

On February 11, 2015, PSW S# 104 was interviewed, indicated that on one evening during that period, care was provided to Resident #02 and altered skin integrity was observed. At that time, PSW S# 104 notified the Registered Practical Nurse (RPN) S# 105 who told her/him to apply barrier cream.

On February 27, 2015, telephone interview with S# 105, indicated that he/she was not aware of any altered skin integrity for Resident #02. Inspector #126 shared the interview with S# 104. RPN S# 105 and he/she assessed the skin of Resident #02. Resident #02 skin was slightly red with no skin breakdown on the affected area. RPN S# 105 told PSW S#104 to apply barrier cream. No documentation was found in the progress notes or in the wound assessment tool as per the home protocol requirement related to this observation.

On February 12, 2015, PSW S# 111 was interviewed, indicated that he/she provided care to Resident # 02 on specific days shift in January 2015. S# 111 indicated that at that time, care was given to Resident #02 as usual. S#111 indicated that he/she was aware of some redness and skin breakdown and that it was an ongoing problem for Resident #02. S# 111 indicated that a white dressing was observed on the affected area. S# 111 indicated that if altered skin integrity was observed the nurse would be notified and could not remember notifying anyone about anything specific regarding Resident #02. No progress notes were found related to altered skin integrity for that specific period of time.

On February 27, 2015, PSW S# 114 was interviewed via telephone .S# 114 indicated

that he/she remembered that on a specific date in January 2015, he/she was working with RPN S# 115 and they provided care to Resident #02 during the night shift. S# 114 indicated that during a change, they observed altered skin integrity in a specific area. S# 114 remembered that S# 115 informed the day shift nursing staff about their observation.

On March 3, 2015, RPN S# 115 was interviewed via telephone. S# 115 indicated he/she remembered working that specific night shift in January 2015. S# 115 observed altered skin integrity of Resident #02. The day shift was made aware of the observation. No documentation was found in the progress notes related to this observation.

Altered skin integrity was observed by PSW S# 106 on a specific day in January 2015. No immediate interventions were done by registered nursing staff after being notified by a PSW. Several registered nursing staff (S#103, 107, 108 and 112) indicated they were not aware or ever notified of the severity of the altered skin integrity until the day Resident #02 was sent to the hospital.

Altered skin integrity was observed on specific days in January 2015 for Resident #02 and Resident #02 did not received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 2nd day of April, 2015

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2015_225126_0005
Log No. / Registre no:	O-001393-14, O-001602-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 13, 2015
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	PETER D. CLARK CENTRE 9 MERIDIAN PLACE, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tony Spenza

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

In order to achieve compliance with O.Reg 79/10 s.50. (2) (b) (ii), the licensee shall prepare, submit and implement a plan to include the following:

Residents that are exhibiting altered skin integrity, including skin breakdown, pressure ulcers will receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection.

All staff involved in residents' care will notify the registered nursing staff immediately of any type of altered skin integrity to ensure timely communication and appropriate treatment.

The registered nursing staff will assess the altered skin integrity and will document the planned interventions and treatment as per the Home's process.

The licensee shall developed and implement a monitoring process to ensure skin care is provided to all residents with altered skin integrity in accordance with the residents care needs.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Linda Harkins by April 7, 2015 via email to linda.harkins@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that Resident #02 received immediate treatment and interventions when exhibiting altered skin integrity.

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Altered skin integrity was observed on specific days in January 2015 for Resident #02 and Resident #02 did not received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection. [s. 50. (2) (b) (ii)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 04, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13th day of March, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

Service Area Office /
Bureau régional de services : Ottawa Service Area Office