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

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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
Jul 9, 2015	2015_384161_0011	O-002171-15	Resident Quality Inspection

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

KATHLEEN SMID (161), ANGELE ALBERT-RITCHIE (545), PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 19, 22, 23, 24, 25, 26, 29, 30, 2015, July 2, 3, 2015

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, President of Residents' Council, President of Family Council, Personal Support Workers (PSW), a Private Sitter, Housekeeping Aides, Maintenance Staff, Registered Practical Nurses (RPN), Registered Nurses (RN), RAI Coordinator, Administrative Assistant, Senior Environmental Service Laundry/Housekeeping, Registered Dietitian, Food Service Workers, Hospitality Manager, Facilities Supervisor, Resident Care Managers and the Acting Administrator.

During the course of the inspection, the inspector(s) also conducted one Complaint inspection log # O-002192-15, four Critical Incident Inspections log #'s O-000330-14, O-002144-15, O-002359-15, O-002387-15, and a Follow-up to Order #O-001764-15 issued previously on March 13, 2015 under Inspection #2015_225126_0005.

During the course of the inspection, the inspector(s) conducted a tour of the Resident care areas, reviewed Residents' health care records, home policies and procedures, staff work routines, posted menus, observed Resident rooms, observed Resident common areas, reviewed the Admission process and Quality Improvement system, observed a medication pass, observed several meal services, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #001	2015_225126_0005	161

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Resident #029 is diagnosed with a dementia among many other conditions, with an Aggressive Behaviour Scale score of 4 out of 12 indicating some level of aggressive behaviour when assessed in the spring of 2015.

During an interview with Resident #029 on a specified date in June 2015, he indicated that he enjoyed joking around with staff and other Residents. The Resident added that he had been told by staff to not joke with female staff as it made them uncomfortable, and to stop teasing Resident #027.

Upon review of the Resident's most recent RAI-MDS 2.0 assessment it was documented that the Resident cognitive status, skills or abilities had deteriorated as compared to 90 days ago, that the Resident was exhibiting socially inappropriate or disruptive behaviours on a daily basis.

Upon review of the Resident's progress notes between April 2015 and June 2015, nine (9) incidents of sexually inappropriate behaviour were documented, such as slapping/patting to female staff on the buttocks while providing care or walking by, making comments about their body parts or making inappropriate sexual advances.

On a specified date in May 2015 it was noted that the Resident required to be monitored

closely as he slapped female staff on the buttocks or made comments about their body parts and on night staff, 2 staff provided care for this reason.

During interview with PSW #S104 on a specified date in June 2015 he indicated that Resident #029 makes sexual inappropriate comments to female staff, added that at lunch today, he observed the Resident tapping PSW #S103 on her buttock. PSW #S104 indicated that he immediately told the Resident "we don't do that and to get out of PSW #S103's space", and added that the Resident stopped the behaviour. The PSW indicated that he was not aware of other behaviours.

During an interview with PSW #S103 on a specified date in June 2015 she indicated that Resident #029 was a friendly Resident who enjoys joking. She added that the Resident had tapped her buttock 2 to 3 times during care provision earlier in the day and once at lunch time. The PSW indicated that she told the Resident to stop, he apologized but did it again soon after. She indicated that she was not aware of other behaviours. After verifying the Resident's most recent Plan of Care, she stated that there was no information in the Resident's plan of care identifying the Resident's inappropriate sexual behaviour towards staff or any other behaviours.

On a specified date in June 2015 during interviews with RPNs #S105 and #S107, they indicated that they were both aware of Resident #029's sexual inappropriate behaviour toward female staff. RPN #S107 indicated that a PSW had reported to her one evening, that the Resident had made sexual comments to her while she was giving him a bath. The both indicated that the Resident's responsive behaviour plan should include Resident's mood and behaviour patterns, the specific responsive behaviours, and potential behavioural triggers and variations in the resident's functioning at different times of the day. RPN #S107 indicated that she would be updating the Plan of Care this evening.

On June 26, 2015 during an interview with Resident Care Manager #S109, he indicated that the printed Plan of Care accessible to staff did not include the planned care for Resident #029 that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the Resident. [s. 6. (1)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview with Resident #029 on a specified date in June 2015 the Inspector observed the Resident in his bedroom, returning from using the bathroom. The Resident was walking without a mobility aid, wearing light gray sweat pants with a large area of wetness in the front. The Resident indicated that he must have dribbled over himself.

Upon review of the Resident's most recent Plan of Care, it indicated that Resident #029 wore incontinence products such as XXL pull-up during the day and full brief at nights, that the Resident was on a toileting schedule plan, was toileted before and after meals and as needed, that the Resident would go to the bathroom on his own and would call for assistance.

During an interview with PSW #S104 on a specified date in June 2015, he indicated that the Resident wore pull-ups during the day, however when he assisted Resident #029 to the bathroom after lunch today, he noticed that the Resident had a full brief on. He removed it and put on a pull-up, added that pull-ups are used during the day to facilitate the task of pulling up and down when the Resident goes to the bathroom on own during the day.

During an interview with PSW #S103 on a specified date in June 2015, she indicated that she was a casual staff on the unit. PSW #S103 indicated she had access to the Resident's plan of care but had not reviewed it. She indicated that she had put on a full brief on the Resident at 07:00 this morning, added that PSW #S104 had informed her around lunch time that the Resident needed a pull-up during the day to make it easier for self-toileting. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee failed to comply with section 33.(3) of the Act in that the licensee failed to ensure that a PASD is used to assist a resident with routine activity of living only if the PASD is included in the resident's plan of care.

Resident #023 was observed throughout the course of the inspection to be seated in a wheelchair with a table top device across the wheelchair. Inspector #138 spoke with PSW #113 regarding Resident #023's table top device and the PSW identified the device as a PASD further stating that the device was applied to assist the resident with positioning while seated in the wheelchair. The inspector noted in the resident's health record that Resident #023 is severely cognitively impaired with a current Cognitive Performance Scale score of 5/6 and most likely not able to remove the table top device related to cognitive abilities. PSW #113 stated to the inspector that the resident has never tried to remove the table top device. PSW #113 further stated that this device was a part of the normal care for this resident and demonstrated to the inspector the flow sheet that captures when the devices is applied, monitored and released. The inspector asked the PSW about the plan of care for the resident and PSW #113 directed the inspector to the hard copy plan of care located in the room with the resident health care records. The inspector obtained the plan of care as directed by PSW #113 and reviewed it along with RN #114 noting that the plan of care did not have any indication that the resident was to use a top table device as a PASD. RN #114 reviewed the resident's electronic health care record and stated to the inspector that the focus of the residents' care plan outling the table top device as a PASD had not been including as part of the plan of care. [s. 33. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that a process to report and locate residents' lost clothing and personal items is implemented.

During an interview with Resident #029's spouse on a specified date in June 2015 it was indicated that the right hearing aid had gone missing approximately one month ago, and that it was reported immediately to a staff member. The spouse indicated that she had not heard from anyone and that the hearing aid was still missing.

The home's Reporting Lost/Misplaced Clothing Items, Policy & Procedure No: 460.12, dated June 2010 and the Lost Article(s) Report - Resident, form 033 were provided by the Administrative Assistant and reviewed by the Inspector. Under the section Procedure, it is documented that:
1. All lost or misplaced items are to be reported to the Registered Nurse/RPN as soon as possible
2. Registered Staff shall verify that the item is lost or misplace by taking appropriate action, e.g. make thorough search, check with other departments and resident's family and complete a Lost Article report
3. The Manager, Hospitality Services is advised through the receipt of a cop of the Lost Articles report and notifies Laundry/Housekeeping staff
4. Laundry staff complete a search of Laundry area and report findings to the Manager, Hospitality Services. Housekeeping staff may assist in the search process

Upon review of the Resident's health record, a note on a specified date in May 2015 indicated that a PSW reported that one side hearing aid was missing and that the registered staff had looked in the room, but had not found it. A note in the 24-hour report for the specified date in May 2015 indicated that Resident #029's hearing aid was missing. [s. 89. (1) (a) (iv)]

Issued on this 9th day of July, 2015

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

Original report signed by the inspector.