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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 16, 2016	2016_384161_0037	023493-16	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 11, 12, 2016

During the course of the inspection, the inspector(s) observed identified residents, reviewed their health care records and select email correspondence.

During the course of the inspection, the inspector(s) spoke with the identified residents, a resident's Substitute Decision Maker, RAI Coordinator, Registered Practical Nurse, Registered Nurse, Program Manager of Personal Care, Program Manager of Resident Care, Enterostomal Therapist and the Administrator.

The following Inspection Protocols were used during this inspection:
Medication
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date in April 2016 the attending physician of resident #001 prescribed a medicated patch to be applied to the resident's ankle daily at 2000 hours and removed at 0800 hours. On a specified date in mid-July 2016 the Substitute Decision Maker (SDM) of resident #001 observed the medicated patch on the resident's chest that was dated five days previously and brought this observation to the attention of Registered Nurse (RN) #104. On August 11, 2016 Inspector #161 discussed this incident with RN #104. She indicated that on a specified date in mid-July 2016 the SDM of resident #001 had brought to her attention that s/he had observed the medicated patch on the resident's chest and that it was dated five days previously. RN #104 examined resident #001 and observed a medicated patch dated five days previously on the resident's chest which RN #104 removed. Inspector #161 reviewed the health care record of resident #001 and noted that RN #104 had recorded the above information in a progress note on a specified date in mid-July 16, 2016. Inspector #161 reviewed the medication administration record of resident #001 for July 2016 and noted that on a specified date in July 2016 at 0800 hours, there were no registered nursing staff initials that indicated that the medicated patch had been removed. Two days after the incident had been reported by the SDM, there was a progress note in the health care record of resident #001 that indicated that the resident's attending MD was informed that the medicated patch had not been administered to resident #001 as prescribed. On August 11, 2016 Inspector #161 discussed this medication incident with the Program Manger of Resident Care who indicated that the Registered Practical Nurse (RPN) that had made the error was currently on vacation. The Program Manager of Resident Care indicated that when the RPN returned from vacation, this error would be discussed with her and that remedial training would be implemented.

On a date in mid-June 2016 the attending physician of resident #002 prescribed a medicated patch to be applied every seven days at 0800 hours. On August 12, 2016 Inspector #161 reviewed the medication administration record of resident #002 for August 2016 and noted that on a specified date in August 2016 at 0800 hours, there were no registered nursing staff initials that indicated that resident #002 had been administered the medicated patch. On August 12, 2016 Inspector #161 discussed this error with RN #108 who indicated that she had inadvertently missed the administration of the medicated patch.

On a specified date in August 2016 the attending physician of resident #003 prescribed that the resident was to receive a specific inhaler (#1) twice daily. On August 12, 2016 Inspector #161 reviewed the medication administration record of resident #003 for

August 2016 and noted that on three consecutive specified dates in August 2016, there were no registered nursing staff initials that indicated that resident #003 had been administered inhaler #2 that had been ordered on a specified date in June 2016. According to the home's medication incident report dated August 2016, RN#110 discovered that RPN #109 had incorrectly discontinued the attending physician's order for inhaler #2 that resulted in resident #003 having missed six doses of the medication. On August 12, 2016 Inspector #161 and Charge Nurse #111 compared the attending physician's medication orders and the resident #003's medication administration record for August 2016, Charge Nurse #111 verified with Inspector #161 that on three consecutive specified dates in August 2016 resident #003 missed the twice daily doses of inhaler #2.

On August 12, 2016 during discussion with Inspector #161, the Program Manager of Resident Care confirmed the medication administration errors related to resident #001, #002, and #003 as described above, and indicated that the residents should have been administered their respective medications as ordered by their attending physicians.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all resident's are administered drugs in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (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 care set out in the plan of care was provided to resident #001 as specified in the plan.

Resident #001 was admitted to the home four years ago with multiple medical diagnoses. In the spring of 2016 the resident was transferred from the home to the hospital with an infected wound. Resident #001’s wound was treated in hospital for 8 days and the resident was transferred back to the home. An Enterostomal Therapist (ET) was providing in-home consultative services regarding resident #001’s plan of care including the treatment of the resident’s wound. As part of this plan of care, every three days the registered staff cleansed the resident’s wound with normal saline, applied a specialized dressing to the wound and covered with another dressing. On August 11, 2016 Inspector #161 was reviewing resident #001’s Treatment Record (TAR) for August 2016. It was noted that there were no registered nursing staff initials on a specified date in August 2016 that indicated that the wound care dressing had been done as per resident #001’s plan of care. On August 11, 2016 Inspector #161 discussed this issue with RPN #105 who indicated that she did not follow perform the wound care dressing on a specified date in August 2016 as the attending physician had looked at resident #001’s wound earlier in the day. On August 11, 2016 discussion held with the ET who indicated that resident #001’s wound care dressing should have been done. On August 11, 2016 Inspector #161 discussed this with the Program Manager of Resident Care who indicated that RPN #105 should have followed the resident’s plan of care related to wound care.

Compliance Order #001 related to LTCHA 2007 S.O. 2007, c.8, s.6(10) related to resident #001’s plan of care was issued on August 4, 2016 by Inspector #547 with a compliance date of November 30, 2016. [s. 6. (7)]

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Issued on this 16th day of August, 2016

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

Original report signed by the inspector.