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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 21, 2016 | 2016_219211_0013 | 017803-16 | 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

JOELLE TAILLEFER (211)

### 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): June 20 and 21, 2016**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Personal Care, Manager of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), visitor, family member and resident.**

**The inspector also observed the resident's room, observed resident common areas and dining room areas, reviewed resident health records, reviewed staff schedules, and reviewed several of the home's policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

1. The licensee has failed to ensure that that there is a written plan of care for resident #001 that sets out clear directions to staff and others who provide direct care to the resident.

During the inspection, Inspector #211 observed a therapy administered to resident #001 through a certain method.

The Physician Order on an identified date, indicated to administer the therapy to a certain amount as needed (PRN) to keep the therapy level over a certain amount for resident #001. The above physician order did not indicate what kind of method the therapy should be administered through.

An additional Physician Order written 16 days later, indicated to assess the therapy level only as needed (PRN).

Interview with the Manager of Care revealed there was no clear direction from the physician on how and when to measure the levels to determine the need to adjust the therapy levels for 16 days and what method should be used to administer the therapy. [s. 6. (1) (c)]

2. The progress notes on an identified date, indicated that the complainant called an RN regarding the therapy level because he/she received a call from the resident's visitor reporting the resident's therapy connection was not properly attached, so may have missed some of the therapy in the morning. The progress notes indicated to check the

resident therapy's connection each shift.

The written plan of care doesn't indicate to verify the therapy's connection each shift as indicated in the progress notes on a identified date to give clear direction to staff what to do to prevent reoccurrence of having the therapy connection separated. [s. 6. (1) (c)]

3. Interview with the complainant revealed on an identified date, he/she received a call in the morning from an identified visitor that resident #001 had a health issue. On that day at 1200 hours, the complainant went to see the resident and he/she was told by the Administrator that the resident was sleeping and the visit scheduled was cancelled. The complainant left the home reluctantly.

Interview with the Administrator on the same day, revealed that the complainant was allowed to see the resident when awake until a certain time. The resident had wished to sleep and not to be disturbed at the time.

The resident's written plan of care on an identified date, does not provide clear direction to staff on situations where visit may not be occurring (e.g. the resident wished to sleep and not be disturbed). [s. 6. (1) (c)]

4. Interview with the complainant revealed he/she wants resident #001's furniture re-arranged the same way it was previously placed because the resident cannot have the wheelchair beside the window to see outside.

The progress notes on an identified date, indicated the resident #001's bed was moved away from the wall to accommodate transfer or repositioning. The complainant was upset about the bed move.

Interview with RPN #102 revealed the complainant was informed frequently that the bed's position needed to be changed for safety reasons due to the electric plug, the resident's call bell and to give access to staff around the bed for care.

During the inspection, the inspector observed that the bed was placed in the middle of the resident #001's room with the head of the bed touching the wall.

Interview with the Manager of Resident Care revealed that the resident's bed in the bedroom needed to be moved from the wall for safety reasons for the resident and the staff. The electric plug on the wall can be dislodged when the staff raised or lowered the

bed. The staff needs to have access around both sides of the bed during transfer. The staff needs to be on both sides of the bed side when the resident is receiving care and when he/she needs to be repositioned. The chair in front of the window can be removed and placed in a different area in the room to accommodate the resident's wheelchair beside the window so the resident can see outside.

The progress notes from an identified date, and the current written plan of care do not provide staff clear directions related to the safety concerns and precautions required to effectively manage these concerns as it related to the placement of the resident's bed and the chair. [s. 6. (1) (c)]

5. Interview with RPN #102 on an identified date at 1307 hours revealed he/she was presently informed by resident's SDM via a telephone call that the identified visitor called the complainant to inform that the resident's health status had changed during the breakfast time. The RPN revealed the resident's therapy level was in the normal range this morning. The identified visitor asked if he/she could bring the resident to an identified area, and at the time the resident did not have a health issue. The specific therapy amount was verified twice during the morning. The RPN verified with the PSWs at 1307 hours if they observed or were told that the resident had a health issue by the identified visitor, and they replied they were not informed.

The resident's written plan of care does not provide clear direction to staff regarding how the identified visitor and the staff will communicate concerns to the SDMs when the resident health status changed or when there are any other concerns brought forward by the identified visitor to the staff. [s. 6. (1) (c)]

6. The written plan of care on an identified date, indicated to verify Resident #001's specific therapy amount by the PSW before meals and activities. The specific amount needs to be verified every two hours when used by the resident.

Review of the written plan of care on an identified date, indicated the resident has a specific therapy that the amount need to be verified by the PSW before the resident comes for meals and goes to any activities.

Interview with PSW #104 revealed the resident's specific therapy amount was verified every three hours.

Interview with RPN #102 revealed the specific therapy administration lasts for three

hours.

Interview with the Manager of Personal Care revealed that the specific therapy administration can be emptied faster than three hours if the amount of therapy levels are increased.

The plan of care does not provide clear directions to staff related to the variable frequency of the specific therapy amount as the flow rate is adjusted to meet the needs of resident #001. [s. 6. (1) (c)]

7. Interview with the complainant revealed he/she is booking a specific area to meet with resident #001's privately while visiting. At times, during this private visit, people will open the door.

Interview with the Manager of Personal Care indicated that he/she was aware of one incident where somebody opened the door while the resident was meeting privately with the complainant. [s. 6. (1) (c)]

8. The progress notes on an identified date at 1042 hours, indicated between 0830 to 0930 hours; the resident #001's visitor approached the Registered Nurse (RN#106) and stated that the resident had a change of condition. The RN found resident sitting on the toilet. The resident was described with a change of condition. The vital signs and the therapy levels were taken. The resident was transferred into bed. The identified RN was informed that the complainant would be visiting at lunch. The identified RN decided to wait until lunch to inform the complainant about resident's health issue. Unknown to the identified RN, the visitor had already called the complainant related to resident #001's health issue in the morning. The daughter arrived at 1015 hours and told the writer "he/she was concerned about the resident's health condition". [s. 6. (1) (c)]

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

Review of Resident #001's current written plan of care indicated to apply a specified garment in the morning and to have them remove before bedtime on a daily basis.

Interview with PSW #107 revealed the specified garment was not applied on an identified date in the morning as indicated in the resident's plan of care. She/he put the resident on the toilet at 0730 hours and brought the resident to the dining room for breakfast. The

resident was given a shower at approximately 1030 hours, and after the shower the resident was transferred directly to the wheelchair and then was sent to an appointment. She/he did not apply the specified garment when the resident was sitting in the wheelchair since it is too difficult to apply when the resident is sitting.

Review of the progress notes on an identified date, indicated Resident #001 returned to the floor from the appointment because the resident was experiencing some health issue and body areas had some swelling. At 1151 hours, resident was transferred to bed with specified body areas elevated. [s. 6. (7)]

***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 the care set out in the plan of care is provided to the resident as specified in the plan and there is written plan of care for the resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan,

policy, protocol, procedure, strategy or system is complied with (reference to O. Reg 79/10 s. 114).

The MediSystem Pharmacy's policy Index Number: 03-01-30 titled "Prescribing-Medication Reviews" dated June 23, 2014, indicated that each resident's medication orders must be reviewed every three months for licensed Long Term Care Facility by following the following procedures:
1. The nurse or authorized care provider will inform the physician/prescriber that the medication review is due.
2. The pharmacy will provide a Physician's Order Review/Digital three Month Review with the current medication orders for each resident prior to the scheduled review date.
3. At least one nurse will compare the newly printed Physician's Order Review/Digital 3 or 6 Month against the resident's current Medication Administration Record, recent physician's order, and last Physician's Order Review/Digital 3 or 6 Month Review to ensure the new review is up-to date before the physician reviews it. Some facilities may choose to have 2 nursing checks. Refer to facility policy.
4. Each drug should be assessed and justified for continued use by the prescriber.
5. The use of more than one drug from the same pharmacological class should be avoided
6. The physician may use this document as an order form. Medication can be continued, discontinued or put on hold by initialing in the appropriate box beside the medication order. Placing a checkmark in the appropriate box is an approved policy and procedure in some facilities. The physician must follow facility policies. Changes should not be made to the exiting printed order. If the medication order is changed (i.e. directions, dosage, drug etc.) the physician is asked to clearly stroke out the old printed order and write the "new" or "change" order in a new blank medication box on the last page. Any new information written on the Digital 3 or 6 Month Review must be done using the digital pen. The order is to contain all pertinent information (i.e. medication name, strength, route, directions, duration etc.)
7. The completed review must be signed and dated by the physician. Changes that have been made using the digital pen on the Digital 3 or 6 Month Review will automatically be transmitted to the pharmacy once the physician has signed the page and docked the pen.
8. The completed Physician's Order Review/Digital 3 or 6 Month Review must then be signed by the nurse in the processed by section, only after all orders have been checked, processed and faxed/transmitted to the pharmacy. Some facilities may choose to have a second nurse check the processed orders. Refer to facility policy.
9. If any changed have been made to the Physician's Order Review (non-digital form),

then it must be faxed to pharmacy as soon as possible. When using the Digital Review form, there is no need to fax the pharmacy; all changes will be transmitted via digital pen.
10. The carbon copy (if provided) of the completed medication review is to be placed in the pharmacy pick-up envelope. The original copy of the Review is filed in the resident's chart in chronological order for future reference.
11. At the time of the Review, all previously ordered medications, which are not listed on the review or added by the physician, are automatically discontinued.
12. Diet, treatment, restraint, physiotherapy and occupational therapy orders must always be complete and reviewed at the time of the review.

The Physician Order on an identified date, indicated to administer the therapy at a certain amount as needed (PRN) to keep the therapy level over a certain degree for resident #001.
The Physician Order Review form for the three months period, indicated to give the therapy at a certain amount to keep the therapy level at a lower degree then it was prescribed on the Physician Order.

Interview with the Manager of Resident Care revealed there was a transcription error from the Physician Order on an identified date into the Physician Order Review form for the three months period , which indicated to give the therapy to a certain amount to keep the therapy level at a lower degree than prescribed on the Physician Order.

Consecutive to the transcription error, the Medication Administration Record (MAR) for a two month period indicated to administer the therapy at a certain amount when needed to keep the therapy level at a certain degree that was lower than the degree prescribed by the Physician Order for resident #001.

The physician on call was paged to clarify the therapy order written in the resident's MAR for the two months. The physician on call ordered that the therapy may be up to a certain level to keep the therapy level to a higher degree.

The clarification of the therapy's telephone order, taken by a nurse from a physician on an identified date, indicated the therapy may be to a certain amount to maintain the level of the therapy higher. On an identified date, there was another telephone order taken by a nurse from a physician indicating to administer the therapy to a certain amount as needed (PRN) to maintain the degree of the therapy level higher and to have a specialized therapist assess.

Interview with RN #103 and the Manager of Resident Care revealed that the MediSystem Pharmacy did not transcribe properly the physician order on an identified date to the Physician's Order Review for the three months period per step #2's procedure of The MediSystem Pharmacy's policy.
The night nurse did not sign one of the four pages of the Physician's Order Review that included the therapy order as per step # 3, 4's procedure of "The MediSystem Pharmacy's policy", so failed to notice the transcription error.

The physician and the day nurse signed the four pages of the Physician's Order Review and did not correct the transcription error, leading staff to believe that the therapy order was to give the therapy to a certain amount to keep therapy level over a certain degree when in fact, the order was supposed to administer the therapy to the certain amount as needed (PRN) to keep therapy level over a higher degree. [s. 8. (1) (b)]

***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 where the Act or this regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.***

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**Issued on this 17th day of August, 2016**

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

**Original report signed by the inspector.**