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
Jun 9, 2017	2017_584161_0010	003905-17, 006306-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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): June 6, 7, 8, 2017.

This complaint inspection is related to a complaint regarding the administration of medication, risk of falls, privacy and skin care.

During the course of the inspection, the inspector(s) spoke with Registered Nursing Staff, Program Manager of Personal Care, Program Manager of Resident Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 a drug was administered to residents #001, #002 and #003 in accordance with the directions for use specified by the prescriber.

On June 7, 2017 Inspector #161 inspected a complaint brought forth on a specified date in February 2017 by the Substitute Decision Maker of resident #001, alleging, that resident #001 had not been administered a prescribed cream the morning of a specified date in February 2017. A review of resident #001's health care records indicated that on a specified date in February 2017, the resident was prescribed a cream to be applied twice daily to the affected area. A review of resident #001's Medication Administration Record (MAR) for the specified date in February 2017 indicated that the prescribed cream had been initialed by RPN #103 as administered. On June 7, 2017 Inspector #161 interviewed RPN #103 who indicated that on the morning of the specified date in February 2017, prior to entering resident #001's room, she had initialled the resident's MAR to indicate that she had administered the prescribed cream. When RPN #103 went into the resident's room she observed that resident #001 was sleeping and she did not want to awaken the resident. RPN #103 placed the prescribed cream at the resident's bedside, with the intention that she would return to administer the prescribed cream to resident #001, when the resident was awake. RPN #103 indicated to Inspector #161 that she forgot to return to resident #001 to administer the prescribed cream.

On June 8, 2017 Inspector #161 reviewed the licensee's Medication Incident Report (MIR) for a specified date in March 2017 related to resident #002. The MIR indicated that on a specified date in March 2017, resident #002 did not receive a prescribed medication at 2000 hours. A review of resident #002's health care records indicated that on an earlier specified date in March 2017, the resident was ordered a medication to be administered daily at 2000 hours. A review of resident #002's Medication Administration Record for the specified date in March 2017 indicated that resident #002 did not receive the medication as prescribed.

On June 8, 2017 Inspector #161 reviewed the licensee's MIR for a specified date in March 2017 related to resident #003. The MIR indicated that on a specified date in March 2017, resident #003 did not receive a medication at 1700 hours. A review of resident #003's health care records indicated that on a specified date in October 2016, the resident was ordered a medication to be administered daily at 1700 hours. A review of resident #003's Medication Administration Record for March 2017 indicated that resident #003 did not receive the medication as prescribed. [s. 131. (2)]

Issued on this 9th day of June, 2017

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

Original report signed by the inspector.