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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2017	2017_582548_0015	012064-17	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

RUZICA SUBOTIC-HOWELL (548)

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): July 25,26,27,31 and August 17, 2017

Complaint related to:infection prevention and control practices, medication management and bathing.

During the course of the inspection the inspector reviewed resident health care records, observed resident care, Infection prevention and control practices, medication incident reports, home specific policies and evidence provided by the Substitute Decision Maker.

During the course of the inspection, the inspector(s) spoke with Substitute Decision Maker, Program Manager of Resident Care, Program Manager of Personal Care, Resident, Registered Nurses, Registered Practical Nurses and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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 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 :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan.

The Substitute Decision-Maker (SDM) indicated that the resident #001 was not repositioned for several hours on a specified day. The SDM indicated that the repositioning schedule is monitored by family members, as the resident requires repositioning every three hours related to compromised skin integrity. The SDM indicated that on a specified day the resident was not repositioned for approximately five hours. The SDM indicated that this has happened on more than one occasion.

The resident #001 is dependent on staff for all activities of daily living and has altered skin integrity to a specific body location.

As care planned, the resident's daily routine is to be repositioned as scheduled. During an interview both RPN #100 and PSW #10 confirmed with the Inspector #548, the resident's current repositioning routine.

Based on the review of the evidence provided by the SDM the Inspector #548 observed that the resident #001 is in the same position and not repositioned as scheduled. The SDM indicated that a family member informed staff and requested the resident be repositioned.

The home requires personal support workers to record the times a resident is repositioned on the document: Repositioning Schedule. The schedule has a legend that prompts the PSW to initial the completion of this intervention and to indicate what position the resident is in and at what time.

The Repositioning Schedule for a specified date indicated that the resident is to be repositioned as per the care plan. Based on the documentation on the flow sheet, for a specified day, it is recorded that the resident #001 is repositioned at a specified time and the next repositioning time recorded is four hours later.

Based on the review of the evidence provided by the SDM for July 2017 (as reviewed by Inspector # 548) the resident #001 is positioned at a specified period of time in the evening and remains in the same position for a specified period of time. Three instances of evidence was provided and reviewed by Inspector #548 to show that the care was not provided as care planned for resident #001. [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 the resident is repositioned as care planned, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the resident #001 of the home is bathed, at a minimum, twice a week by method of his or her choice.

A complaint from the resident's #001 SDM was received on a specified day related to missed baths.

During an interview with the Inspector 548 the SDM indicated that the resident #001 had not had full body baths in the months of May and July. The SDM indicated that should the staffing levels be lower than usual the resident receives a partial bath with no hair washing or is told that the bath will be rescheduled for a later date. The SDM added that the family have not witnessed the rescheduled bath or washing of the resident`s hair. The SDM indicated that the resident was not receiving scheduled baths as the resident's lower extremities were odorous.

The resident #001 is fully dependent for all activities of daily living. The resident #001's current care plan specifies that two staff members will provide assistance on scheduled bath days (two per week on specified days) and, the procedure for washing the resident's hair. The resident is scheduled on the units posted Bath Schedule.

Review of the home's flow sheets – 'Bath' was conducted for May and July 2017. The flow sheet prompts the Personal Support Workers (PSW) to indicate the type of bath provided and if the resident's #001 hair had been washed.

In May 2017 the resident was scheduled to be bathed on specified days for a total of nine bath days in the month. Review of the May 2017 Bath flow sheets indicated that the resident #001 received baths on specified days for a total of eight bath days for the month. On two specified days there is no record that the resident #001's hair had been washed.

Review of the July 2017 Bath flow sheets on a specified day that the resident's hair had not been washed and a partial bed bath had been provided.

During an interview with the Inspector #548, PSW #101 indicated that a partial bed bath will be provided when there is a shortage of staff. She indicated that baths are to be rescheduled either later that day or later in the week.

During an interview with the Inspector #548, RPN #100 indicated that the staff look for a day and time to reschedule baths for residents if they are short staffed or based on resident needs.

Review of the staffing levels for specific dates was conducted with the Staffing Coordinator. The schedule shows that there was a full complement of staff scheduled and working on the two days where there is no record that the resident #001's hair had been washed.

The licensee failed to ensure that the resident #001 received the minimal twice weekly bathing, as required. [s. 33. (1)]

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 the resident is bathed at a minimum twice weekly, to be implemented voluntarily.

WN #3: 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 :

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

The medication management system written policy on Medication Administration, policy #345.3, approved on June 2016 specifies that registered nursing staff must exercise vigilance when administering medications and to ensure that the ten rights of administering medications are adhered to. The ten rights are: the right resident, the right medication, the right dose, the right frequency, the right time, the right course, the right site, the right reason, the right response/effect and the right documentation.

A complaint from the resident #001's SDM was received related to a discontinued medication that had been administered to the resident. During an interview the SDM indicated that the physician had ordered a stoppage of a specific medication for three days, however a dose was administered.

The resident #001 was routinely prescribed and administered the specific medication on a daily basis.

Upon notification that the resident`s #001 health status had changed, the physician ordered that a medication be stopped for three days.

Review of the Medication Incident Report (MIR) MIR #05104 indicated that resident #001 was administered a dose of the specific medication.

The licensee failed to ensure that drugs are administered to resident #001 in accordance with the directions for use as specified. [s. 131. (2)]

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 drugs are administered as specified, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

This non-compliance is related to concerns expressed by resident #001's SDM that staff were not following the principles of Infection Prevention and Control (IPAC) while caring for the resident and, that the resident's personal care equipment is not being cleaned and disinfected properly.

1. Based on a review of the evidence provided by the SDM, the SDM indicated that staff were not demonstrating adherence to IPAC practices while providing care to the resident #001.

Based on a review of the evidence provided by the SDM for a specified day and time. The Inspector #548 observed two PSWs (PSW #001 and PSW #002) enter the room, both wearing gloves. PSW #001 provides peri-care to resident #001 perineal area, the resident is turned and PSW #002 washes and applies lotion to the resident's bottom.Without changing gloves, the two PSWs reposition the resident in bed. PSW #001 enters the bathroom, turns on the tap comes back into the room and touches the resident's pillow. PSW #002 lifts the resident's head, touches the remote control to the bed increasing the elevation of the head of the bed. PSW #001 and #002 leave the room.

PSW #001 turns off the light switch.

All of these actions were conducted by PSWs without removing or changing gloves.

Based on the review of evidence provided by the SDM the Inspector #548 observed the same scenario for two other specified days.

On August 17, 2017 during an interview with the inspector #548 the Program Manager of Personal Care (PMoPC), lead for the IPAC program at the home, indicated that she has been made aware of the SDMs concerns that staff were not changing their gloves. She indicated that staff are to remove gloves and perform hand hygiene as per the policy. She added that she has spoken with the staff and is conducting hand hygiene audits in response.

The home's Hand Hygiene Policy, 825.07 revision date August 2016 specifies that hand hygiene is to be conducted before and after taking off gloves, between tasks and procedures on the same resident in an attempt to prevent cross contamination of different body sites. The procedure for hand sanitizing is explained and states that a 70 to 90 percent alcohol based hand rub (ABHR) is the preferred method for cleaning the hands. Cleaning of hands is to be conducted in the resident's bed space or room according to the four moments for hand hygiene.

Inspector #548 observed an ABHR pump was available in the resident's room.

2. On a specified day Inspector #548 observed a cleaner/disinfectant called Saber spray to be in the resident's bathroom. During an interview with the Inspector #548 PSW #101 indicated that the bed bath basin is used for the resident's bed bath and after use she uses Saber Spray to clean and disinfect the basin. She indicated that she sprays the entire surface of the basin waits about 30 seconds and rinses and wipes it dry prior to placing in under the sink for storage.

An email addressed to the PMoPC on a specified day from the resident #001's SDM informing the PMoPC of the observation that face cloths are being placed in the blue wash basin prior to the washing of the resident's #001 face.

Based on a review of the evidence provided by the SDM Inspector #548 observed (in the presence of the SDM) that on a specified day and time a PSW used the blue bath basin to wash the resident's #001 face. Once completed the PSW sprays the basin with the

spray in the bathroom, immediately rinses the basin and places it in storage.

Based on a review of the evidence provided by the SDM for a specified day and time the Inspector #548 observed evening care being provided to resident #001. Post care the PSW rinses the blue bath basin with water and placed it in storage in the resident's bathroom.

Based on a review of the evidence provided by the SDM for a specified day and time the Inspector #548 observed a PSW use the blue basin to provide peri-care to the resident, empty the basin, rinse it with water and place it in storage. Later the same day, the blue basin is used by two PSWs to provide the resident peri-care in the evening. The basin's contents are emptied into the sink, the basin is left to rest in the sink on its side. The SDM enters the bathroom and proceeds to clean the blue basin.

On a specified day and time Inspector #548 observed two PSWs provide morning care to resident #001. It was observed that the resident's #001 blue wash basin is filled with fresh water by PSW #101. PSW #101 proceeds to provide peri-care. Once completed PSW #101 emptied the contents of the basin into the sink, sprayed the surface of the basin with Saber spray, wets a clean cloth, wipes the blue basin and then wiped it dry with a dry cloth. This procedure took approximately 15 seconds.

On August 17, 2017 during an interview with the inspector #548 the PMoPC indicated that she has been made aware of the SDMs concerns regarding the cleaning of blue basins. She indicated that there is a specific procedure that staff are to use to clean residents' personal care equipment. She indicated that the product Saber is currently being used for the cleaning and disinfecting of blue wash basins and that all PSWs had received training on how to use the Saber spray for residents' personal care equipment.

The home's policy 'Cleaning of Resident Care Equipment, 845.01, revised on March 2017 specifies that bath basins are to be wiped or sprayed with an appropriate disinfectant after each use.

Manufacturer instructions were provided from the PMoPC to Inspector #548 on August 17, 2017. Saber spray is a cleaner, disinfectant, sanitizer, bactericidal and general virucide designed for institutional use and health care facilities. The PMoPC specified that the Saber spray was to be applied to the full surface of the blue basin, left for five minutes and rinsed off. She added, that blue basins are used for bed baths and personal care only. She further added, that washing of the face is conducted with clean face cloths

that are made wet from a running tap.

An email correspondence, related to the cleaning of resident equipment, from the Program Manager of Resident Care directed to regulated nursing staff makes reference that regulated staff discuss the home's policy (above) with staff.

An email correspondence for a specified day in April 2017, titled 'Infection Control Reminder' from the PMoPC to regulated nursing staff in the home indicated that there are several bathing points required to be reviewed with staff in an attempt to reduce the risk of infections. One point made was that the washing of the (residents) face is to be conducted with clean cloths that are made wet from a running tap. [s. 229. (4)]

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 staff adhere to the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate action taken to assess and maintain the resident’s health.

A complaint was received from the resident #001's SDM regarding a medication incident where the resident was administered a routine medication that had been placed on hold by the physician.

The resident is prescribed the medication on a daily basis. On a specified day the physician was notified that there was a change in the resident's health condition. The physician ordered a specific medication to be stopped for a specific period of time.

The resident #001 was administered a dose of the specific medication post physician order for it to be stopped.

On July 26, 2017 during an interview with Program Manager of Resident Care she indicated that following medication incidents, assessments would be recorded in the residents' progress notes. She further explained that the home documents by exception and if there were any issues related to the medication incident it would be recorded there.

Review of the progress notes was conducted.

There is no record of the immediate actions taken to assess and maintain resident’s #001 health after the medication incident was identified. [s. 135. (1)]

Issued on this 19th day of September, 2017

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

Original report signed by the inspector.