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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 21, 2017	2017_617148_0028	022374-17, 023285-17, 023360-17	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

AMANDA NIXON (148)

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): September 27, 28, 29 and October 2, 3, 11, 12, 20 and 23, 2017, on site.

This inspection included three complaint logs related to an identified resident; items of complaint included alleged incidents of resident abuse, retaliation and provision of care including medication administration and repositioning.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Program Manager of Resident Care, Attending Physician, Registered Nurses, Registered Practical Nurses, Personal Support Workers and family members.

The Inspector conducted several observations of the identified resident, reviewed the resident's health care record including physician orders, medication administration records, plan of care and care flow sheets. In addition, the Inspector reviewed other evidence related to resident care, the home's policy to promote zero tolerance of abuse and neglect and documents related to a complaint of a specified date.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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, as it relates to the need for repositioning.

Resident #001 is dependent on staff for all activities of daily living, including positioning and repositioning in bed. Based on the review of the evidence provided by the family, concerns arose related to the repositioning provided to resident #001 between the hours of 0430 and 0630.

The plan of care for resident #001, along with the Repositioning Schedule used by staff to document the time of day repositioning is provided, describes that the resident requires two staff physical assist and is to be turned left side to right side every two hours when in bed.

On a specified date, evidence provided by the family, demonstrates that repositioning was provided at approximately 0430 hours by two staff members, whereby the resident was turned from the right side to the left side. Based on this same evidence it was demonstrated that staff entered the room of resident #001 two more times between 0430 and 0645 hours, however, no repositioning was provided.

The Inspector spoke with PSW #106, who provided care on the specified date. PSW #106 was asked to describe the resident's repositioning schedule, to which she reported that the resident is repositioned at 0030, 0230 and 0430 hours. In addition to the repositioning schedule, PSW #106 reported that there is a check of the resident between 0430 hours and the end of shift at 0700 hours. The documentation maintained by staff on the same shift indicates the last repositioning was provided at 0430 hours, left side.

Resident #001 was not provided with the care set out in the plan of care, on a specified date, as it relates to the required repositioning every two hours, specifically at approximately 0630 hours. [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 resident #001, specifically as it relates to repositioning, to be implemented voluntarily.

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 failed to ensure that 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.

In accordance with section 114 of Regulation 79/10, the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

As it relates to WN #3 of this report, whereby a regular dose of medication was not administered to resident #001 in accordance with the directions for use specified by the prescriber, the Inspector reviewed a specific medication management system policy. Upon request by the Inspector, the home's Program Manager of Resident Care provided

a policy titled Digital MAR (Medication Administration Record)/TAR and Electronic Medication Administration Systems, revised January 2017. The policy includes the following instructions as it relates to "Checking new digiMAR Sheets":
#6 Upon receipt of the new digiMAR sheets, two nurses or facility authorized care providers are to check all printed information for correctness, make appropriate corrections and inform pharmacy of any changes;
#7 To ensure accuracy, each new sheet must be double checked against the Physician's Order Review, as well as the previous month's digiMAR sheets before being used;
#9 The two nurses or care providers who double check the digiMAR sheets must sign in the appropriate spaces at the bottom of the sheets.

In review of the digiMAR sheet for resident #001, used by staff to document the administration of the pain mediation during a specified period of time, there is no documentation to support that a nurse or authorized care provider checked the printed information for correctness; there is no signatures in the appropriate spaces at the bottom of the sheet.

In review of the digiMAR sheet for resident #001, used by staff to document the administration of the pain medication during a specified period of time, there is one nurse signature. There is no signature to support that a second nurse or authorized care provider checked all printed information for correctness. In an interview with the home's Program Manager for Resident Care, it was stated that the nurses should have checked the orders for correctness.

As such the licensee failed to ensure that the medication management system policy, titled Digital MAR/TAR and Electronic Medication Administration Systems, related to checks of the digiMAR, was complied with. [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 that policies related to the medication management system, specifically those related to ensuring the accuracy of digiMAR sheets, are complied with, 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 licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A family member of resident #001 described concerns of medication administration to Inspector #148. Specifically, concerns that a medication, that was scheduled for a specified time, was being provided to the resident prior to the registered nursing staff conducting an assessment. Further to this, the family member reported that the administration of the medication was occurring at a different specified time then scheduled.

Resident #001 returned from a leave on a specified date, with a physician order for regular medication every six hours. On the same date, the order and administration times were written for every six hours; this information was communicated to the home's pharmacy service provider. Upon the receipt of the Medication Administration Record (digiMAR), the administration times had been adjusted to include three doses, six hours apart and a forth dose within four hours. The digiMARs for a specific period of time were reviewed and included documentation to support that the regular medication was administered, at times, within four hours of a previous dose.

In an interview with RPN# 109, who was familiar with the administration of this medication, it was reported that resident #001 was provided a dose at a time of day whereby a dose would be within four hours of the previous dose. In an interview with the home's Program Manager of Resident Care (PMRC), it was determined that a concern related to the administration of the medication had been brought forward to the PMRC by the resident's family member on a specified date. The PMRC reported to the Inspector that the digiMAR was not clear and that one of the administration times was not every six hours as per the physicians order. As such the order was clarified on the same day the concern was brought forward to the PMRC, whereby the administration times were changed to reflect every six hours.

The physician order specified for a regular medication to be administered every six hours. The planned administration time of the medication, in addition to the actual time of administration of the medication did not ensure that the medication was administered to resident #001 in accordance with the directions for use specified by the prescriber. [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 that drugs administered to resident #001 are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect resident #001 from emotional abuse by anyone.

In accordance with O. Regulation 79/10, section 2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Resident #001 has a diagnosis of unspecified dementia and other related diagnosis. The resident is dependent on staff for all activities of daily living. During interactions with Inspector #148, the resident did not respond to questions.

During the course of this inspection, Inspector #148 reviewed evidence provided by the family, related to incidents of alleged abuse. The evidence demonstrated that on four specified days, PSW #100 made remarks directed at resident #001, that were of a threatening and intimidating nature, while in the presence of a second PSW. In this way PSW #100 was emotionally abusive toward resident #001.

The licensee was issued a Compliance Order of the Director on July 19, 2017, pursuant to LTCHA, 2007 S.O. 2007, s.8, s.19 (1). The Order was issued due to the scope and severity of non-compliance related to section 19 and section 6 of the LTCHA, 2007; the Order is to be complied with by December 1, 2017. The findings described above, as it relates resident #001 and section 19 of the LTCHA 2007, is linked to the Compliance Order of the Director issued July 19, 2017. [s. 19. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, is complied with.

The home's Program Manager of Resident Care, identified the licensee's policy to promote zero tolerance of abuse and neglect, as policy #750.65 titled Abuse, last revised June 2017. Under the heading "Practice", the policy states the following: "Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from other residents, families, volunteers or employees (for definitions please see appendix A)". Appendix A, defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident.

In accordance with O. Regulation 79/10, section 2(1), emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Resident #001 has a diagnosis of unspecified dementia and other related diagnosis. The resident is dependent on staff for all activities of daily living. During interactions with Inspector #148, the resident did not respond to questions.

During the course of this inspection, Inspector #148 reviewed evidence provided by the family, related to incidents of alleged abuse. The evidence demonstrated that on four specified days, PSW #100 made remarks directed at resident #001, that were of a threatening and intimidating nature, while in the presence of a second PSW. In this way PSW #100 was emotionally abusive toward resident #001.

Issued on this 22nd day of January, 2018

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

Original report signed by the inspector.