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

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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
Feb 5, 2018	2017_708548_0027	021537-17, 022789-17, 023054-17, 026654-17	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), 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): December 6,7,8,13,18,19,20 and 21, 2017

During the course of the inspection the inspector reviewed residents health care records and investigative notes, observed residents and, staff to resident interactions.

Inspection 2017_617148_0036 was conducted concurrently with this inspection.

Logs #: 021537-17 related to alleged neglect
022789-17related to alleged abuse
023054-17 related to Plan of Care
026654-17 related to alleged abuse

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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 LTCHA, 2007, 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. Log #022789-17

The licensee failed to ensure that the care set out in the plan of care is provided to resident #004 as specified in the plan.

Resident #004 has had several verbal and physical altercations with co-residents. Although, when interviewed by Inspector #548 had no recollection of past altercations.

The resident's care plan specifies that co-residents react either verbally or physically in response to resident #004's responsive behaviours.

The Inspector #548 reviewed resident #004's health care record.

The resident #004's current care plan specifies interventions as a means to decrease the demonstration of episodes of reactive responsive behaviours towards others.

On December 6, 2017 Inspector #548 did not observe a specified intervention to be provided to resident #004.

On December 7 and 11, 2017 Inspector #548 did not observe the specified responsive behavior intervention to be provided to resident #004.

On December 11, 2017 during an interview with RN #118 he indicated that he was not made aware that the intervention was not currently being implemented. Several days later, the Inspector #548 observed on December 20, 2017 the specified intervention had been provided.

2. The licensee has failed to ensure that care set out in the plan of care is provided to resident #005 as specified in the plan.

A complaint was received from the Substitute Decision Maker (SDM) related to staff not following the resident's #005 plan of care, specifically related to continence care and management interventions.

Resident #005 continence care and management interventions specify a toileting plan and the use of a specific size and colour of continence product (brief). PSW #116 provided the most recent care plan (from the care plan binder) to Inspector #548 for review. It indicated that the resident #005 was to be provided a brief of a specific size and colour.

On December 8, 2017 during an interview with Inspector #548, PSW #116 indicated that the resident is on a toileting schedule and wears a brief. PSW #116 indicated that the

brief does not appear to be working well, as there had been episodes of fluid seepage. PSW #116 showed Inspector #548 the briefs supplied to the resident. The product was a specific colour and was labelled a specific size. On the same day, PSW #115 indicated that the resident #005 had episodes where the brief was not sufficient for the resident's fluid output. Both PSWs indicated that a specific brief (based on the colour and sizing label) was being used for the resident. Upon review of the care plan and the brief shown to the Inspector #548, it was apparent that the brief being used and the brief identified in the plan of care differed.

The home failed to provide the proper sized brief to resident # 005, as specified in the plan of care. [s. 6. (7)]

It is noted that a Director's Order related to LTCHA s. 6 (7) Plan of Care was issued to the City of Ottawa on July 19, 2017 as part of a Director Referral under Inspection # 2017_620126_0004, made in accordance with s. 152, paragraph 4 of the Long-Term Care Homes Act, 2007 (LTCHA). The Director's Order compliance due date was December 1, 2017. It is noted that the above finding of non-compliance issued under LTCHA s. 6 (7) occurred prior to the December 1, 2017 compliance due date.

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.