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
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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
May 23, 2018	2018_583117_0002	029097-17, 000035-18	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

LYNE DUCHESNE (117), 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): March 5, 6, 7 and 8, 2018 on-site, March 19 and May 18, 2018 off-site

The following complaint inspections were completed during this inspection:
- 029097-17 a complaint related to drug administration
- 000035-18 a complaint related to a resident plan of care

During the course of the inspection, the inspector(s) spoke with the Program Manager for Resident Care, the acting Program Manager for Personal Care, several registered nursing staff members (RN and RPN), several personal support workers (PSW) as well as to a resident family member.

During the course of the inspection, the inspector reviewed a resident health care record, medication administration records, medication incident reports, digital video footage provided by the resident's family, the City of Ottawa policies: policy #345.3 on Medication Administration approved June 2016, policy #325.11 on Incident Reporting: Resident revised August 2016 and policy #725.04 on Plan of Care and Care Planning revised February 2018.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. Log 000035-18

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.

The Substitute Decision Maker (SDM) informed the Ministry that resident #001 was not being turned every two hours, in accordance with the resident's plan of care. By way of digital video footage, an identified family member of resident #001, reported that on a specified date in 2018, the resident's repositioning between specific hours of time, was of concern.

Resident #001 is dependent on staff for all activities of daily living, including positioning and repositioning in bed. The resident's room is equipped with audio/visual recording equipment that is motion activated, as installed by the resident's family.

The plan of care for resident #001 includes specific direction related repositioning as follows: the resident requires two staff physical assist and is to be turned side to side every two hours when in bed. The resident #001's repositioning schedule specifies the times, at two hour increments, that the resident is to be repositioned. A document titled: Repositioning Schedule, is used by staff to document the time repositioning is provided, this document describes that the resident is to be repositioned every two hour.

On a specified day in 2018 a recording of the digital video clip viewed by the Inspector, demonstrates that repositioning was provided at an identified time by two staff members. The next available video begins four (4) hours later, at which time a staff member is seen to walk into the room, with a manual lift.

Staff members: Program Manager of Personal Care (PMoPC) #102, Registered Nurse (RN) #105 and Personal Support Workers (PSWs) #103, #104 and #108 all reported that the resident #001's repositioning schedule is set for every two hours while in bed and there is documentation of this intervention on the "Repositioning Schedule" form. Review of the form in the presence of the PMoPC "Repositioning Schedule" dated for a specific day in 2018 resulted in no documentation that the resident was repositioned between two identified hours.

Interviews with Registered Practical Nurse #109 and PSW #108 both indicated that they do not recall if they had repositioned the resident on the specified day in 2018 between the identified hours as there were several issues encountered during that period of time where they were required to meet the needs of other residents.

The licensee failed to ensure that care set out in the plan of care for resident #001 was provided as specified in the plan between identified hours, on a specified day in 2018.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk or potential for actual harm/risk to resident #001. The scope of the issue was a level 1 as it related to one resident. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

• Director Referral issued on July 19, 2017, Inspection # 2017_620126_0004
• Written Notification (WN) issued on December 5, 2017, Inspection # 2017_708548_0027
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on September 26, 2017, Inspection # 2017_617148_0028
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on July 25, 2017, Inspection # 2017_582548_0015
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on January 21, 2017, Inspection # 2017_584161_0004
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on December 19, 2017, Inspection # 2016_582548_0031
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on August 11, 2016, Inspection # 2016_384161_0037
• Written Notification (WN) and Voluntary Plan of Correction (VPC) issued on June 14, 2016, Inspection # 2016_219211_0013
• Written Notification (WN) issued on May 16, 2016, Inspection # 2016_284545_0013
• Written Notification (WN) issued on June 24, 2015, Inspection # 2015_384161_0011 [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 114(3) (a). The licensee was required to ensure that: The written policies and protocols must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Specifically, staff did not comply with the licensee's 'Medication: Administration' policy, 345.3, Approval date: June 2016, which is a part of the licensee's medication management system.

The resident's #001 Substitute Decision Maker (SDM) indicated that the resident was transported to hospital with a change in health status on a specified day in 2017. The SDM indicated that a copy of the resident's Medication Administration Record (MAR) that accompanied the resident to hospital was incomplete and delayed initial health care interventions upon initial assessment of the resident. The SDM further explained that there was no initial on the MAR to indicate if a prescribed medication had been administered at a specific time. The SDM indicated that the attending physician was not able to rule out if the resident's presenting symptoms were related to a medication or not, delaying interventions.

The licensee's medication management policy ' Medication: Administration' policy, 345.3, Approval date: June 2016, specifies the following items are to be completed by Registered nursing staff: that when RN/RPN are to make sure of the right documentation

when administering medication.

On March 5, 2018 at 1425 hours during an interview with Inspector # 548, Registered Practical Nurse (RPN) #101 indicated that the resident was administered the specified medication at the specified time. The RPN indicated that on the day that the resident's condition changed and the RPN informed the Registered Nurse (RN) #105 of the resident #001's change in health status. The RPN indicated that the RN #105 instructed staff to prepare to transport the resident to hospital. The following day RPN #101 indicated that he/she was informed by RN #105 that he/she had not signed off the MAR for the specified medication indicating that the medication had been administered at a specific time and did so at that time.

On March 7, 2018 at 0930 hours during an interview with Inspector #548, Program Manager of Personal Care (PMoPC), indicated that the required documentation and the practice is to initial on the MAR that a medication had been administered. The PMoPC indicated that the RPN #101 had not adhered to policy. [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 o ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was 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 resident #001 drugs are administered in accordance with the directions for use specified by the prescriber.

Resident #001 returned to the home on a specified day in 2018, from hospital with a prescription for a specific medication to complete a seven (7) day treatment course for an identified medical diagnosis. The hospital sent the resident #001 back to the long-term care home with a three (3) day supply of the prescribed medication.

RN #105 explained the process of medication reconciliation when a resident is transferred from hospital to the home. RN #105 indicated all discharge notes and prescriptions are reviewed by the receiving registered nursing staff. The prescription orders are manually transferred on a form 'Re-Admission Order Form'. The form lists all of the medications prescribed to the resident. The form is then faxed to the home's pharmacy provider.

From a review of the 'Re-Admission Order Form' the medication was transcribed with some components of the prescription in reverse.

The home's Medication Incident Report (MIR) indicated that the transcription error occurred and that the medication was not available. RN #105 indicated that the prescription was not prescribed correctly onto the MAR and the pharmacy provider had not sent the medication to the home to continue with the therapy. Consequently, resident #001 was not administered the specified medication on a specified day in 2018. The medication error was discovered on the next day. The attending physician and resident Substitute Decision Maker (SDM) were notified of the medication error that same day. The medication order was not renewed post consultation with the SDM. The resident was monitored and no adverse effects were noted.

The licensee failed to ensure that resident #001 was administered a specified medication 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 are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNE DUCHESNE (117), RUZICA SUBOTIC-HOWELL (548)
Inspection No. / No de l'inspection :	2018_583117_0002
Log No. / No de registre :	029097-17, 000035-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 23, 2018
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Peter D. Clark Centre 9 Meridian Place, OTTAWA, ON, K2G-6P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ted Cohen

To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA s. 6 (7).

Specifically, the licensee shall ensure that resident #001 is repositioned every two (2) hours when in bed, as specified in the plan of care.

Nursing staff who provide direct care to resident #001 during a specified shift must review the contents of the resident's plan of care at the start of each identified shift.

Repositioning of resident #001, when in bed, must be documented immediately following the provision of care and validated as being provided by the registered nursing staff in charge of the resident home area before the end of the identified shift.

Grounds / Motifs :

1. Log 000035-18

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.

The Substitute Decision Maker (SDM) informed the Ministry that resident #001 was not being turned every two hours, in accordance with the resident's plan of care. By way of digital video footage, an identified family member of resident #001, reported that on a specified date in 2018, the resident's repositioning between specific hours of time, was of concern.

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issue was a level 1 as it related to one resident. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

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• Written Notification (WN) issued on May 16, 2016, Inspection # 2016_284545_0013
• Written Notification (WN) issued on June 24, 2015, Inspection # 2015_384161_0011

(548)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

Service Area Office / Bureau régional de services : Ottawa Service Area Office