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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2018	2018_770178_0020	012675-18, 013293-18, 016253-18, 025233-18	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

SUSAN LUI (178)

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): October 9, 10, 11, 12, 16, 17, 18, 2018.

This inspection involved the following Critical Incident Logs:
-#012675-18 (CIR #M609-000033-18), regarding an allegation of improper care of a resident
-#016253-18 (CIR #M609-000036-18), regarding an allegation of staff to resident emotional and physical abuse.
This inspection involved the following Complaint Logs:
-#013293-18, regarding alleged staff to resident neglect and improper care
-#025233-18, regarding alleged staff to resident physical abuse and improper care.

This inspection report also contains evidence from:
-Inspection #2018_770178_0019, which concerned Complaint Log #008985-18, regarding alleged emotional abuse of a resident.
-Inspection #2018_730593_0014, which concerned Critical Incident Log #024689-17, regarding alleged staff to resident abuse.
-Inspection #2018_593573_0015, which concerned Critical Incident Log #005405-18, regarding unknown cause of an injury to a resident for which the resident is taken to hospital.

During the course of the inspection, the inspector(s) spoke with family members of a resident, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Program Manager of Resident Care, Acting Program Manager of Personal Care, and a physician.

During the course of the inspection, the inspector also observed staff/resident interactions, reviewed a resident's health record, reviewed home records of investigations into allegations of abuse and improper care, and reviewed the Licensee's policy to promote zero tolerance of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 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	Légende 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director under the LTCHA.

Critical Incident Report (CIR) #M609-000036-18 was submitted by the licensee to the MOHLTC on an identified date, to report an allegation of abuse of a resident by two staff members. The CIR indicated that the allegation would be investigated by the licensee. No amendment was made to the CIR to indicate the results of the investigation.

During an interview with Inspector #178 on October 10, 2018, the Program Manager of Personal Care indicated that the allegations of abuse reported in CIR #M609-000036-18 were investigated, but that the results of the investigation were not reported to the Director under the LTCHA as required. [s. 23. (2)]

2. The following finding of non-compliance is from Inspection #2018_770178_0019 / 008985-18, 019909-18, 022434-18:

On an identified date, the home submitted an email written by the Program Manager of Hospitality, outlining a complaint made by visitor/friend #105 on behalf of resident #002. The complaint alleged that the prior night someone entered resident #002's room while the resident slept, moved two identified items from the usual places the resident kept them, and damaged a small item belonging to resident #002. The email indicated that the resident was upset and felt that this was an act of retaliation from a PSW who the resident had previously reported to the home's management.

Inspector # 178 interviewed the Program Manager of Hospitality (PMOH) on October 4, 2018. The PMOH indicated that visitor/friend #105 reported resident #002's allegations of retaliation to home management. The PMOH indicated that after being made aware of

the allegations, they interviewed resident #002, and the resident was very upset about the incident, and the resident felt victimized as a result of the incident. The PMOH indicated that the incident was investigated by the home's Program Manager of Personal Care at the time, and that no evidence was found to indicate who had moved the items and damaged the resident's property. The Manager of Hospitality was unsure whether the results of the investigation were ever reported to the Director under the LTCHA.

Review of the Critical Incident System revealed no report of resident #002's allegations of retaliation, or the results of the licensee's investigation into the resident's allegations.

During an interview with Inspector #178 on October 9, 2018, the Administrator indicated that the home could find no indication that the results of the investigation into resident #002's allegation of retaliation or emotional abuse was reported to the Ministry of Health and Long-Term Care.

As such, the licensee has failed to ensure that the results of an investigation into allegations of abuse were reported to the Director under the LTCHA. [s. 23. (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 the results of any abuse or neglect investigations are reported to the Director under the LTCHA, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director under the LTCHA.

During an interview with Inspector #178 on October 9, 2018, family member #111 indicated that in the summer of 2018, they reported to the home's former Administrator and to the acting Program Manager of Personal Care (PMOPC-A), that they witnessed staff bathing their loved one in a rough and improper manner. Family member #111 indicated that during this care their loved one expressed discomfort as a result of the rough care. Review of Critical Incident Reports (CIRs) submitted by the licensee to the Ministry of Health and Long-Term Care (MOHLTC) indicated no report of this allegation.

During an interview with Inspector #178 on October 11, 2018, the PMOPC-A indicated that they had no memory of family member #111 reporting this allegation, but that notes in the investigation file into other concerns expressed by family member #111 contain references to an allegation of improper and rough care during a bath. The PMOPC-A indicated that notes taken by the former Administrator indicated that family member #111 had brought forward concerns about the bath to the Administrator on an identified date,

along with other concerns. The PMOPC-A indicated that the investigation file contained notes indicating that they investigated all the concerns brought forward by family member #111, but that not all of family member #111's concerns were included in the CIR submitted by the licensee to the MOHLTC. The PMOPC-A indicated that it was an oversight that the allegation of the improper bath was not included in the CIR submitted by the licensee.

Inspector #178 reviewed CIR # M609-000036-18, submitted by the licensee on an identified date. The CIR reports other concerns expressed by family member #111 regarding their loved one's care, but does not include the allegation that a bath was provided in a rough and improper manner. [s. 24. (1)]

2. The following finding of non-compliance is from Inspection #2018_593573_0015/005405-18:

On an identified date, a Critical Incident Report #M609-000015-18 was submitted to the Director of the Ministry of Health and Long -Term Care related to resident #006's unknown/ unexplained bruising and swelling in an identified area of the body. The CIR report indicated that resident was transferred to the hospital and diagnosed with a fracture in an identified area of the body

Inspector spoke with RN #114, who indicated that on an identified date, resident #006 was assessed for bruising, swelling and redness in an identified area of the body. The RN stated that resident #006 was transferred to hospital for assessment due to possible suspected fracture. Further, RN #114 stated to Inspector #573 that staff members on the unit were questioned related to resident #006's unexplained bruising and swelling in an identified area of the body.

On October 03, 2018, Inspector #573 spoke with the acting Program Manager of Personal Care (PMOPC), who stated that on an identified date, resident #006's unexplained bruising and swelling in an identified area of the body was reported by RN #114. The acting PMOPC indicated that on the same day an investigation was conducted with the staff members on the unit, and the acting PMOPC was unable to determine the cause of resident #006's injury. Further, the acting PMOPC confirmed with the inspector that resident #006's unexplained bruising was not reported immediately to the Director. (Log #005405-18) [s. 24. (1) 1.]

3. The following finding of non-compliance is from Inspection #2018_730593_0014/024689-17:

The licensee has failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to resident #007, has immediately reported the suspicion and the information upon which it is based to the Director.

A critical incident (CIS) was submitted to the Director on an identified date, detailing alleged abuse toward resident #007. The CIS described the incident as the RPN entering resident #002's room to change their brief with resident #007 describing the RPN's manner as abrupt and their approach impatient. Resident #007 said that the RPN yanked their brief and hurt their groin. When resident #007 complained, the RPN said that "they won't change the resident next time".

As per the CIS as well as investigation records, the incident occurred on an identified date and time; however was not reported to the Director until approximately two and one half days later.
During an interview with Inspector #593, October 2, 2018, the Program Manager of Resident Care (PMORC) indicated the incident may have been reported late due to the time that resident #007 reported the incident however they cannot be certain. Inspector #593 reviewed the resident's health care records as well as the investigation records for this incident and the resident's statement or interview were not documented neither was the time that the resident reported the incident to the home or who the incident was reported to. [s. 24. (1) 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 the person who has reasonable grounds to suspect that Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

Critical Incident Report #M609-000036-18 was submitted by the licensee to the MOHLTC. The report indicated that family member #111 reported witnessing a staff member being rough when providing care to their loved one. The CIR was submitted by the Program Manager of Personal Care (PMOPC), and indicated that the police would be notified of the allegation.

During an interview with Inspector #178 on October 10, 2018, the PMOPC indicated that they submitted CIR #M609-000036-18, reporting that family member #111 had alleged that staff had been rough in positioning their loved one. The PMOPC indicated that they would have reported the allegation to the police because it was reported as suspected abuse. However, on October 11, 2018, the Manager, Personal Care indicated that they were unable to find a police case file, and they realized that they had not in fact reported the allegation of abuse to the police. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 19th day of November, 2018

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

Original report signed by the inspector.