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

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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
Jan 15, 2019	2018_559142_0016	031792-18	Resident Quality Inspection

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

JANET MCPARLAND (142), MICHELLE EDWARDS (655)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 10th-14th, 17th, 19th-21st, 2018 and January 2nd-4th, 2019.

The following intakes were completed with this Resident Quality Inspection:
-Log # 009299-18: complaint related to alleged resident abuse and neglect as well as the home's medication management system
-Log #'s 019902-18 (CIR# M609-000043-18), 026797-18 (CIR# M609-000056-18) and 006070-18 (CIR# M609-000019-18): related to falls and transfer to hospital with injury

During the course of the inspection, the inspector(s) spoke with residents, families, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Registered Dietitian (RD), Dietary Aides, Hospitality Manager, Manager of Recreation, Leisure and Volunteers, the Resident Council Chair, the Family Council Chair, Program Manager- Resident Care, Program Manager- Personal Care and the Administrator.

In addition, during the course of the inspection, the inspectors conducted a tour of the home, reviewed several resident health care records, observed the provision of resident care and services, staff to resident interactions, observed medication administration, reviewed the medication management system, as well as resident and family council meeting minutes and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

Over the course of the inspection, Inspector #655 reviewed the health care record belonging to resident #012, related to nutrition and hydration needs. In the health care record, resident #012 was identified as being at risk of choking; and as such staff were to avoid providing the resident with "crumbly and dry food". In a note by the Registered Dietician, and in a current care plan document, resident #012 was identified as requiring a specific intervention.

During the inspection, Inspector #655 spoke with staff members including PSWs and Dietary/Food Services staff who were not aware of the specific intervention required by resident #012. During meal time observations, Inspector #655 was unable to verify whether the intervention was being provided.

During an interview, PSW # 119 indicated to Inspector #655 that any particular nutrition or hydration interventions in place for a resident would be implemented by the dietary or food services staff during meal times.

During an interview, Food Services Staff (FSS) #124 who was working on resident #012's resident home area at the time of the interview but who normally worked at a different location, indicated to Inspector #655 that information about a resident's plan of care related to dietary needs is normally kept on a dietary list which they would refer to in

order to identify a particular resident's requirements. At the time of the interview, FSS # 124 reviewed the dietary list for resident #012's resident home area, and found that there was no direction included on the dietary list with regards to resident #012's specific intervention. FSS #124 was not aware that this intervention was part of resident #012's plan of care.

During an interview, RD #121 indicated to Inspector #655 that if the resident's plan of care includes a specific intervention, it should be identified on the applicable diet list. At the time of the interview, RD #121 confirmed that the specific intervention for resident #012 was not on the diet list.

The licensee has failed to ensure that there was a written plan of care for resident #012 that set out clear directions to dietary staff with regards to resident #012's need for a specific intervention. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident, 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 has 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.

As per O.Reg. 79/10 s.136(2) The drug destruction and disposal policy must also provide for the following:
4. That drugs that are to be destroyed are destroyed in accordance with subsection (3).

As per O.Reg. 79/10 s. 136 (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and

(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

(6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

The Licensee's policy Medication Disposal Non Controlled/Controlled (P & P No: 345.02) indicates that for non-controlled medications:
2. At time of disposal a registered staff will remove the medication from the medication strips/card, together with a second team member place surplus medication in the tamper proof, disposal bin supplied.
3. Monthly, water will be poured into container to render the medication inactive before being removed from the home area.

Inspector #142 inspected the medications rooms throughout the Home and observed white disposal medication bins in each of the medication rooms. Registered staff indicated the bins were for disposal of non-controlled medications.
Inspector #142 observed that the majority of medications within the disposal bins remained in their original medication strip packages. It was also noted that within the bins there were treatment creams and medications in bottles.

Furthermore, Inspector #142 noted that the disposal bins in the medication rooms on the resident home areas on Maple, Willow, Elm and the Bungalows were not sealed in a tamper proof container. Inspector #142 and registered staff were able to remove the lids from the bins.

Inspector #142 conducted interviews with several registered staff (#'s 100, 102, 106, 107, 109, 113, 125, 126, 127, 128) regarding the destruction of non-controlled medication. Some of the registered staff interviewed indicated that medications remain in their original packaging and are placed directly into the medication disposal bins until it is picked up by an outside vendor. In addition, some of the registered staff interviewed indicated that they removed the medications from the strip packages and placed into the disposal bin, however, they were not aware if or when water was added to the container to render the medication inactive. Inspector #142 noted that there was no water in the disposal bins to render the medications inactive, and in one instance, a bin in the Pine medication room the bin was filled to capacity.

In addition, in interviews with registered staff, they indicated that recently the vendor who provided the disposal bins did not send the correct lids for the bins. Registered staff further indicated that the lids were locked when the bin was full.

In an interview with the Manager-Resident Care they indicated that registered staff are to remove the medication from the medication strips and water is poured into the container to destroy the medications. Th Manager- Resident Care, also indicated that the vendor who provided the disposal bins did not sent the correct lids for the bins.

The Licensee failed to ensure that registered staff complied with the Licensee policy related to the disposal of non controlled medications.(Log #009299-18) [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 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 (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every use of a physical device to restrain a

resident under section 31 of the Act, the following was documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response, every release of the device; and all repositioning.

i. Resident #012

Over the course of the inspection, resident #012 was observed by Inspector #655 to be seated in a tilted wheelchair with a front-closure lap belt in place.

In resident #012's health care record, the front-closure lap belt was identified as a restraint. Over the course of the inspection, RPN #109 also described resident #012's lap belt as a restraint.

During an interview, PSW #111 indicated to Inspector #655 that typically, the PSW assigned to resident #012's care would be the one to apply and remove the resident's lap belt on a given day. PSW #111 further indicated to Inspector #655 that resident #012 was required to be monitored on an hourly basis when the lap belt was in use, and repositioned every two hours and when needed. According to PSW #111 each application of the lap belt, as well as the hourly monitoring and repositioning of resident #012 was to be documented by the PSW on a monitoring form ("Repositioning-Restraint-PASD-Monitoring Form").

Inspector #655 reviewed the "Repositioning-Restraint-PASD-Monitoring Form" dated December, 2018, used by staff for the purpose of documentation related to resident #012's lap belt restraint in the presence of PSW #111, and observed several gaps in the documentation between December 1 and December 19, 2018.

On several dates, the entries were made using alternate symbols, which were not consistent with the corresponding legend, where A = Applied, M = Monitored, R = Removed, D = Declined, RP = Repositioned.

On an identified date in December 2018, there was no record of who applied the lap belt, though the documentation indicated that the lap belt was removed at 2030 hours that day. Between 0730 hours and 1430 hours on the same day, there was also no record of any hourly monitoring or repositioning of resident #012; and no record of the resident's response.

In addition to the above, no documentation was found on the following dates and times:

- two identified dates in December 2018, between 0730 hours and 1430 hours,
- identified date in December 2018, between 2330 hours and 0630 hours; and,
- identified date in December 2018, between 0730 hours and 0930 hours.

At that time of the review, PSW #111 indicated to Inspector #655 that they were unsure why there were gaps in the documentation.

During an interview, Inspector #655 reviewed the above-described gaps in the documentation for resident #012 with RPN #109. RPN #109 indicated to Inspector #655 that resident #012 is typically up in their wheelchair by a specific time each morning; and that the lap belt restraint would always be applied when the resident was in their chair. At the same time, RPN #109 indicated to Inspector #655 that even when the resident was not in their chair, an entry is expected to be made on the monitoring sheet to indicate that the lap belt was not in place at that time.

During an interview, Manager of Personal Care (MPC) #104 indicated the same. At the same time, MPC #104 reviewed the restraint monitoring form used for resident #012 and confirmed that there were several gaps in the documentation. MPC #104 further indicated to Inspector #655 that changes to the monitoring form and processes have resulted in confusion for staff who are expected to document on the restraint monitoring form. MPC #104 further indicated that gaps in PSW documentation related to restraint monitoring has been identified as an area for improvement in the home.

ii. Resident #017

Over the course of the inspection, resident #017 was also observed by Inspector #655 to be seated in a tilted wheelchair with a front-closure lap belt in place. In resident #017's health care record, the lap belt was identified as being a physical restraint.

During an interview, PSW #112 indicated to Inspector #655 that resident #017 required a lap belt to prevent the resident from moving around in their chair, and falling. PSW #112 provided Inspector #655 with the "Repositioning-Restraint-PASD-Monitoring Form" dated December, 2018, used by staff for the purpose of documentation related to resident #017's lap belt restraint.

Inspector #655 reviewed the above-noted restraint monitoring form, and found several

gaps in the documentation between December 1, 2018, and December 31, 2018.

On several dates, the entries made on the restraint monitoring form did not demonstrate that resident #017 had been repositioned every two hours during the day shift, as required (for example, several identified dates in December 2018); and, on several dates, the entries were made using alternate symbols, which were not consistent with the corresponding legend as previously described.

On an identified date in December 2018, there was no indication as to when the lap belt restraint had been applied, although the records indicated that the lap belt was removed at 2030 hours that day.

On an identified date in December 2018, there was no record of the resident's response between the hours of 0730 and 1430.

In addition to the above, there was no documentation found on the following dates and times:

-two identified dates in December 2018 between 0730 hours and 0930 hours,
-two identified dates in December 2018, between 0730 hours and 0930 hours,
-identified date in December 2018, between 0730 hours and 0930 hours; and,
-identified date in December 2018, between 0530 hours and 0830 hours.

As described above, both RPN #109 and MPC #104 confirmed over the course of the inspection that entries were expected to be made at all times on the restraint monitoring form, even when the resident is not restrained in order to record that the device was not in place. MPC #104 further indicated that gaps in documentation by PSW staff on the restraint forms was a known issue and had been identified as an area of improvement.

The licensee has failed to ensure that for the use of a physical device to restrain resident #'s 012 and 017, under section 31 of the Act, the following was documented: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response, every release of the device; and all repositioning. [s. 110. (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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post restraining care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee failed to ensure that only residents of the long-term care home were members of the Residents' Council.

Inspector #655 reviewed Residents' Council meeting minutes dated October 1, October 24, and November 28, 2018, respectively.

On review of the meeting minutes, Inspector #655 noted that in two of the three meeting minutes reviewed, a resident's Substitute Decision Maker (SDM) was identified as having had attended the Residents' Council meetings. It was further noted by the Inspector that, according to the meeting minutes, several of the concerns identified during Residents' Council meetings had been brought forward by this individual, who was not a resident of the long-term care home.

During an interview, Manager of Recreation, Leisure, and Volunteers (MRLV) #117 confirmed that a specific SDM (who did not reside in the home) had been attending Residents' Council meeting minutes, and that residents had expressed concern about this. MRLV #117 indicated to Inspector #655 that starting in 2019, only residents' may attend residents' council; and that others will then only be permitted to attend a Residents ' Council meeting if invited.

The licensee failed to ensure that only residents of the long-term care home were members of the Residents' Council. [s. 56. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents' Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee and the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of the Residents' Council only when invited.

During an interview, the Residents' Council President indicated to Inspector #655 that they were not sure whether the licensee, Administrator, and staff of the home attend Residents' Council meetings only when they were invited to do so.

Inspector #655 reviewed the Residents' Council meeting minutes dated October 1, October 24, and November 28, 2018, respectively.

On review of the meeting minutes, Inspector #655 noted that several members of management were identified as attendees, including: the Administrator, the Manager of Recreation, Leisure, and Volunteers (MRLV #117); and, the Manager of Hospitality; as well as other staff members including Activities Coordinator #123, and a Social Worker.

Over the course of the inspection, Activities Coordinator #123 was identified as being assigned to assist the Residents' Council. Activities Coordinator #123 was unavailable during the inspection, and therefore Inspector #655 was advised to speak with the Manager of their department, the MRLV #117.

During an interview, MRLV #117 indicated to inspector #655 that managers have been attending Residents' Council meetings and that the requirement for an invitation had fallen "through the cracks". MRLV #117 indicated to Inspector #655 that beginning in 2019, individuals other than family members will be able to attend a Residents' Council meeting only if invited.

The licensee failed to ensure that the licensee and the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of the Residents' Council only when invited. [s. 64.]

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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*

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.