Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jul 10, 2019	2019_593573_0018	011589-19	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

ANANDRAJ NATARAJAN (573)

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): July 04, 05 and 08, 2019

Complaint Log #011589 -19 concerns related to resident care/ services was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Personal Care (PMOPC), the Program Manager of Resident Care (PMORC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and Activity Coordinator.

During the course of the inspection, the inspector reviewed resident health records, reviewed licensee staffing plan documents and schedule. In addition, the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Recreation and Social Activities
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan: (c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident (d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) (e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A complaint log was submitted to the Ministry of Long-Term Care, that indicated concerns regarding continuity of care to the resident, by the nursing and personal support services staff members.

During an interview, the Administrator indicated that the following number of Personal Support Worker (PSW) staff members are to work on a specified unit during a 24 hours period:
- Day Shift - 0700 hours to 1500 hours: 5 PSWs
- Evening Shift - 1500 hours to 2300 hours: 5 PSWs
- Night Shift - 2300 hours to 0700 hours: 1 PSW

A review of the PSW weekend schedules for two specified months in 2019, for an identified unit, indicated that the unit worked short of one PSW on 10 shifts out of 54 shifts. Furthermore, the review of the PSW staff schedule for the specified unit, indicated that approximately more than 45 PSWs worked on those identified weekend shifts.

The licensee staffing plan documents were reviewed with the Administrator. Upon review, it was noted that written staffing plan did not provide any information to promote the continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident. Furthermore, the staffing plan did not include a written back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage).

The Administrator indicated to the inspector that the licensee's staffing plan was reviewed annually. When inspector requested the evaluation date of this document, the Administrator was unable to provide any documentation regarding the date of evaluation nor any evidence to support that the written staffing plan was evaluated and updated annually. [s. 31. (3)]

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 staffing plan: (1) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident (2) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work (including 24/7 RN coverage) (3) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: 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 resident #001's written plan of care set out clear direction to staff and others who provide direct care to the resident, specifically in relation to resident #001's responsive behaviours.

A review of resident #001's nursing progress notes for two specified months in 2019, included numerous documentation of resident #001's wandering into other resident rooms and exit seeking behaviours. The progress notes also indicated that resident #001 wanders into co-resident's rooms, takes their belongings thereby upsetting other residents in the unit.

On June 04, 2019, Inspector #573 reviewed resident #001's written plan of care in place, which identified resident has wandering behaviour in the unit related to cognitive impairment. Furthermore, the written plan of care failed to identify resident #001's wandering behaviour into other resident rooms and the exit seeking behaviours.

During an interview with PSW #101, they indicated to Inspector #573 that they were not the regular PSW staff on the unit. PSW #101 stated to the inspector that they were assigned to provide care to resident #001. PSW #101 indicated to inspector that they were not aware of resident #001's wandering behaviour into other resident rooms nor the exit seeking behaviours.

Inspector spoke with RN #102, who indicated that resident #001's behaviours were managed with monitoring, redirection and gentle approach. RN #102 indicated that resident #001 was currently seen by the Behavioural Supports Ontario (BSO) team and Psycho Geriatric Team to manage the resident's responsive behaviours. Inspector #573 reviewed resident #001's written plan in the presence of RN #102. After the review of resident #001's written plan of care, the RN indicated that the written plan of care failed to identify resident #001's wandering into other resident rooms and the exit seeking behaviours. Furthermore, the RN indicated that written plan of care did not provide clear directions to staff regarding how to manage resident's wandering behaviour into other resident rooms. [s. 6. (1) (c)]

Issued on this 31st day of July, 2019

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

Original report signed by the inspector.