Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2020	2020_627138_0002	024036-19	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

PAULA MACDONALD (138)

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): January 28, February 3, 4, 5, 6, and 7, 2020.

Intake #024036-19 relating to resident care concerns was inspected as part of this complaint inspection.

During the course of the inspection, the inspector(s) spoke with an activities coordinator, an administrative assistant, the Administrator, a driver/technician, the Manager, Resident Care, personal support workers, a registered dietitian, registered practical nurses, a registered nurse, and a staffing coordinator.

The inspector reviewed resident health care records, observed a resident, observed a resident room, reviewed internal investigation documents, and reviewed the complaint process.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent and complement each other as it relates to a specific therapy for resident #001.

Resident #001 receives a specific therapy via portable devices for specific activities. The care plan outlines that the portable devices are to be maintained at two specific times and the electronic Administration Record (eMAR) further outlines that the portable devices are maintained at an additional time, outlining that the portable devices are maintained every 2 hours.

RPN #117 stated that resident #001 receives the specific therapy via portable devices starting each day at an approximate time and confirming that the portable devices are maintained every 2 hours. RPN #117 stated that the portable devices will last for about 2 hours under perfect conditions but further stated that there are times when the portable devices do not last that long.

A driver/technician from the supply company of the portable devices was interviewed about resident #001. Driver/technician #120 stated that the portable devices for the resident can last 2.1 hours under perfect conditions but stated that prefect conditions may not be normal conditions. The driver/technician further stated that it is recommended to check the portable devices when in use every 1.5 hours.

The resident was observed on February 5, 2020, attending activities using the specific portable device. It was noted that the portable device did not last 2 hours and instead lasted approximately 1.5 hours.

As such, the plan of care for resident #001 outlining the maintenance of the portable devices every 2 hours is not consistent and complementary of the driver/technician's recommendation of checking the portable device every 1.5 hours. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care relating to a specific therapy was provided to resident #001 as specified in the plan.

Resident #001's care plan outlines that the resident receives a specific therapy. Further, the eMAR used by registered nursing staff to provide care indicates that the resident is to receive the specific therapy and it outlines specific intervals in which registered nursing staff are to monitor. RN #106 also stated that the resident requires the specific therapy at all times.

RPN #119 reported that at the beginning of a specific shift they had observed resident #001 in their bed not receiving the specific therapy. RPN #119 reapplied the therapy and then spoke to RN #106 about their discovery.

RN #106 stated that, in response, they had completed an assessment on resident #001. RN #106 stated that the resident was assessed to have specific outcomes.

The health care record supports RN #106's statement, indicating these outcomes. The progress notes also stated that the resident had additional complaints that were treated with effect.

As such, resident #001 did not receive a specific therapy according to the resident's plan of care and this lack of therapy resulted in harm to the resident that had been resolved. [s. 6. (7)]

3. The licensee failed to ensure that the provision of the care set out in the plan of care are documented with respected to a specific therapy for resident #001.

Resident #001 receives a specific therapy and the eMAR outlines that registered nursing staff are to ensure and document that the therapy had been monitored at specific intervals.

Resident #001 was found not receiving the therapy on a specific date. The resident suffered specific outcomes as a result.

The eMAR was reviewed for this incident and it was noted that there was no entry indicating that registered nursing staff ensured that the therapy was monitored at a specific hour on the same date as the incident.

The eMARs were then reviewed for a specific, extended period. It was noted that 14% of the required entries by registered nursing staff related to this therapy were not documented.

As such, the licensee failed to ensure that a specific therapy for resident #001 was consistently documented. [s. 6. (9) 1.]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 19th day of February, 2020

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

Original report signed by the inspector.