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

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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
Oct 27, 2020	2020_617148_0009	002939-20	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

AMANDA NIXON (148)

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): September 21-25, 28-30 and October 1, 2 and 8, 2020

The following intake was completed in this complaint inspection: Log 002939-20 related to medication administration, skin and wound care, use of support devices and infection prevention and control.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care (PMRC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Rehabilitation Assistant and Personal Support Workers (PSWs). During the course of the inspection, the inspector observed resident care, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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. 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 :

The licensee has failed to ensure the Medication Management System policy for the destruction and disposal of all drugs, was complied with for a resident.

Ontario Regulation 79/10, s. 114(2) requires that written policies and protocols are developed for medication management to ensure the destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home’s policy and procedure "Medication Administration”, dated November 2019.

The Medication Administration policy states that unused medication shall be discarded into the destruction and disposal bin for destruction and disposal.

A seven-day treatment of a medication was ordered for a resident. After approximately three weeks, the medication remained in the medication cart and an RPN administered the medication to the resident in error.

Sources: Medical orders, Medication Incident Report, Medication Administration policy #315.12 (dated November 2019) and interview with an RPN.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The Skin and Wound Tool and/or the Wound Tracker may be used as the clinically appropriate assessment instrument for assessment of altered skin integrity, such as redness of the skin.

A resident was seen to have altered skin integrity. The same altered skin integrity was noted on three subsequent dates by an RN and two RPNs. No skin assessment was completed using a clinically appropriate assessment instrument during that time.

An RPN saw the altered skin integrity and noted that the skin condition had worsened. The resident was then assessed using the Wound Tracker assessment tool.

Source: Progress notes, Bath Records, Wound Tracker and interviews with RNs and RPNs, PMRC and other staff.

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 :

The licensee has failed to ensure that a drug was administered to a resident, in accordance with the directions for use specified by the prescriber.

On one occasion, a resident was given the incorrect medication by an RPN.

Sources: Medical orders for a resident, Medication Incident Report, interviews with an RPN.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

The licensee has failed to ensure that the effectiveness of a drug was monitored and documented for a resident.

A resident was given a medication for pain relief, however, there was no documentation of the resident’s response or the effectiveness of the drug.

Source: Electronic Medication Administration Record, Medication Administration Record Notes, Medication Incident Report, interview with PMRC.

Issued on this 28th day of October, 2020

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

Original report signed by the inspector.