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
Feb 18, 2021	2021_593573_0002	012308-20, 012866-20, 012874-20, 013100-20, 017041-20, 017520-20, 020573-20, 023955-20, 000890-21	Critical Incident System

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), JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 11 -15, 18 - 22, 25 - 29, and February 01, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

- Log (s): #012308-20, #012866-20, #012874-20, #017041-20, #017520-20 and #000890 -21 were related to a fall incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

- Log #013100-20 and #023955-20, were related to injury to the resident with unknown cause.

- Log #020573-20 was related to improper care of a resident that resulted in harm to the resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care (PMRC), Acting Program Manager of Personal Care (PMPC), RAI Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection the inspector reviewed the identified resident's health care records and other pertinent documents. In addition, inspector observed the provision of care to the residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services

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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident's plan of care indicated that the resident required two staff total assistance for the continence care/ change of incontinent product. Inspector spoke with the acting Program Manager of Personal Care regarding the resident's Critical Incident Report, the acting PMPC stated that internal investigations revealed that the PSW provided the care and changed the resident's incontinent product independently without the second staff member assistance. The PSW did not follow the specified resident's plan of care, there was actual harm to the resident.

Sources: Resident's plan of care, interview with acting PMPC. [s. 6. (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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, that a post-fall assessment is conducted using a clinically appropriate instrument that is specifically designed for falls.

A resident suffered a fall with an injury and transferred to hospital for further management. A post-fall assessment using a clinically appropriate tool was not completed for this specific fall incident.

Sources: Post fall assessments, progress notes, and interviews with RN and Program Manager of Resident Care. [s. 49. (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 when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for the purpose.

Resident's health record, indicated that after a fall incident the resident complained of pain and difficulty in walking. Resident's medication administration record indicated that post fall, pain medications were administered to the resident for three subsequent days. The RAI Coordinator stated that the resident's pain was not assessed using the clinically appropriate assessment instrument specifically designed for this purpose.

Sources: Resident's progress notes, medication administration record (MAR), and pain assessments. Interview with the RAI Coordinator. [s. 52. (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 when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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Issued on this 18th day of February, 2021

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

Original report signed by the inspector.