Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: June 3, 2024	
Inspection Number: 2024-1604-0002	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Peter D. Clark Centre, Ottawa	
Lead Inspector Karen Buness (720483)	Inspector Digital Signature
Additional Inspector(s) Shevon Thompson (000731)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 10, 13, 14, 15, 16, 17, 2024

The following intake(s) were inspected:

- Intake: #00111498 and Intake: #00114068 related to the fall of resident which resulted in a significant change in health status
- Intake: #00112359 and Intake: #00114064 related to suspected staff to resident physical abuse
- Intake: #00114249 related to suspected staff to resident emotional abuse
- Intake: #00115476 related to improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Restraints / Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rationale and Summary:

In a review of a resident's progress notes a Registered Nurse (RN) documented a referral for the resident to be assessed for a bed alarm.

In a review of the resident's current care plan, it was noted that there was no intervention for the use of a bed alarm for the resident. A review of the unit flow sheet binder revealed the flow sheets for the resident did not contain any information or intervention in regard to a bed alarm for the resident. A review of the documents titled, individualized plan of care and Kardex, located in the resident's room closet reveled neither document had any intervention for the use of a bed alarm.

During an observation, the inspector noted a sign on the wall, over the resident's bed, with instructions on how to reset a bed alarm. On the same day a bed alarm was noted to be on the resident's bed.

In interviews conducted with a Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) they confirmed that the resident used a bed alarm. Later on the same day in an interview with a Registered Nurse (RN) they confirmed that the resident used a bed alarm and that the resident's plan of care had been updated to include an intervention for the use of the bed alarm.

The inspector confirmed, in a review of the resident's plan of care, that it had been updated to include an intervention for the use of a bed alarm.

Sources: observations, resident's electronic and paper document health record, interviews with a PSW, a RPN and a RN

[000731]

Date Remedy Implemented: May 17, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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;

The licensee has failed to ensure that the written plan of care for a resident set out the planned care for the resident.

Rationale and Summary:

When interviewed regarding the assistance provided by staff related to continence care, a resident stated they found having the option to use a urinal helpful.

The resident's written plan of care indicated the resident required one staff extensive assistance for toileting but did not include the use of a urinal as an intervention.

When interviewed, the Nurse Practitioner (NP) stated when providing assistance with toileting the staff will ask the resident if they would prefer to use the toilet or the urinal. The NP also reported the use of a urinal should be included in the written plan of care. At the time of the interview the NP was made aware the use of the urinal was not included in the resident's plan of care.

During an interview held with a PSW they stated the resident preferred to use the washroom but they offered the resident the urinal. The PSW also stated this direction was provided by the registered staff during shift report.

Prior to the conclusion of the inspection the Director of Care (DOC) approached the inspector and stated the resident's written plan of care had been updated to include the use of the urinal as per the resident's preference.

After the discussion with the DOC, the resident written plan of care was reviewed again and the inspector confirmed the written plan of care had been updated to include the use of a urinal as per the resident's preference.

Sources: Resident electronic health records, interview with the resident, the Nurse Practitioner, the Director of Care and a PSW

[720483]

Date Remedy Implemented: May 16, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary:

The inspector reviewed two documents observed in the resident's room on the closet door. A document titled Individualized plan of care and another titled Kardex were noted to contain different information for the interventions related to walking, falls, and behaviour.

In a review of the resident's current care plan, the inspector noted the interventions were consistent with the interventions in the Kardex but not with the document titled Individualized plan of care.

During an interview a PSW, they confirmed that the interventions for the resident's care could be found in the care plan, kardex and the individual plan of care. They could not confirm if the information in all the documents should be the same or different.

A RPN reviewed the documents titled Individualized plan of care and the Kardex in the resident's room closet and confirmed that the two documents were expected to contain the same interventions. They verified that the interventions in the individualized plan of care document was out of date.

In an interview with a RN they confirmed that the interventions in the residents Individualized plan of care and Kardex documents were expected to be the same.

The Manager of Personal Care confirmed that the Individualized plan of care and the Kardex documents in the resident's room, posted on the closet door, were expected

to contain the same interventions for the resident.

Failure to ensure that the written plan of care for the resident, set out clear directions to staff and others who provide direct care to the resident placed the resident at risk for not having their care needs met.

Sources: resident electronic and hard copy health record, interviews with a PSW a RPN a RN, and the Manager of Personal Care

[000731]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary:

A resident was found sitting in her wheelchair with a sheet wrapped around the wheelchair. The sheet was tied in a knot at the back of the wheelchair.

The licensee's Resident Abuse and Neglect policy and procedure directs the Administrator / delegate to immediately remove the staff member under allegation from the resident area(s) and place on Investigatory Leave pending the outcome of the investigation.

A review of the licensee's investigation notes and staff schedule revealed that one of the alleged employees was immediately placed on investigatory leave as per policy but an additional alleged staff member continued to work in the home.

When interviewed, the Director of Care stated initially only one of the staff members was suspected to have tied the sheet around the wheelchair but while conducting an internal investigation interview an additional staff member was suspected to be involved. The Director of Care confirmed this staff member worked one shift in the home after they were suspected to be involved.

Failure of the licensee to follow their Resident Abuse and Neglect policy put the resident at an increased risk of harm.

Source: Licensee's investigation notes, staff schedules and interviews with the Director of Care

[720483]

WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 38 (a)
Prohibited devices that limit movement

s. 38. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or

The licensee has failed to ensure that no device provided for in the regulations is used on a resident to restrain the resident, specifically sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

Rationale and Summary:

A resident was found sitting in wheelchair with a sheet wrapped around the wheelchair which was tied in the back. Upon discovery the sheet was untied and the resident was assessed and no injury was noted.

A review of the licensee's internal investigation notes and an interview with the Director of Care confirmed the incident.

Using a prohibited device to restrain the resident put the resident at risk of injury.

Sources: Resident electronic health records, licensee's internal investigation notes and an interview with the Director of Care

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