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 |
|---|---|---|---|
| Apr 4, 2022 | 2022_935483_0007 | 018904-21 | Critical Incident System |

### Licensee/Titulaire de permis

Royal Ottawa Health Care Group
1145 Carling Avenue Ottawa ON K1Z 7K4

### Long-Term Care Home/Foyer de soins de longue durée

Royal Ottawa Place
1145 Carling Avenue Ottawa ON K1Z 7K4

### Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KAREN BUNESS (720483)

## 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): March 10, 11, 14, 15, 2022**

**The following intake was completed in this Critical Incident System (CIS) inspection: Log # 018904-21/CIS 2933-000005-21 related to Hospitalization and Significant Change.**
**Inspector #593 was present throughout the course of the inspection as an observer.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the DOC, the Infection Control and Prevention Coordinator, the RN Infection Control and Prevention Designate, the Environmental Services Manager, the RPN Resource Nurse, 1 RN, I RPN, 1 screener and 3 PSWs**

**The inspector reviewed relevant residents' clinical records, plans of care, pertinent policies and procedures and observed resident and staff interactions.**

**The following Inspection Protocols were used during this inspection:**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Personal Support Services**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the hand hygiene program was in place in accordance with r.299. (4), specifically related to assisting residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals.

Meal service observations in 2 resident dining rooms revealed residents did not receive prompting to wash their hands or were assisted with hand washing before or after the meal service.

The Director of Care DOC indicated that it is the responsibility of the staff to ensure that residents hands are washed before and after meals.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario- Best Practices for Hand Hygiene in all Health Care Settings, 4th edition (April 2014), observation of meal service, interview with a RPN and the Director of Care. [s. 229. (4)]

***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 ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.***

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**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 resident #001's plan of care set out clear direction to staff and others who provided direct care to the resident O.Reg 79/10 s 6. (1) (c)

Resident sustained an injury which required being sent to hospital and resulted in a significant change in condition. A review of the resident's clinical record showed that the care plan was not updated upon return from hospital. Interviews with PSW and registered staff revealed there was no clear direction provided in regards on how to safely transfer, position and provide care to the resident. The Director of Care indicated the it is the expectation that the care plan be reviewed and updated when residents return from hospital with a significant change in condition.

Sources : Resident #001’s clinical record, care plan and progress notes, interview with a PSW, a RN and the Director of Care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #003’s plan of care set out clear direction to staff and others who provided direct care to the resident O.Reg 79/10 s 6. (1) (c)

Resident #003 was sent to hospital and resulted in a significant change in condition. A review of the resident’s clinical record showed the care plan was not updated upon return from hospital which resulted in staff not receiving direction on changes in the resident's plan of care

Sources : Resident #003’s electronic clinical record. [s. 6. (1) (c)]

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**Issued on this 4th day of April, 2022**

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

**Original report signed by the inspector.**