Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 12, 2013	2013_193150_0033	O-001144-13	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET, VANIER, ON, K1L-5C6

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

CAROLE BARIL (150)

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): December 5, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse, Personal Support Worker, Physiotherapist and the resident.

During the course of the inspection, the inspector(s) reviewed the resident's health care records, Fall Prevention Program revised March 2013, home's policy in Reporting Incident #750.56 revised October 2013.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Pain

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6 (10) (b) in that the resident plan of care was not reviewed when the resident's care needs change upon the resident's return from the hospital.

On a specific date in October 2013, the Resident #01 had a fall with no related symptoms of pain or fracture.

During the inspection the Resident #01 progress notes were reviewed from September 28 to November 30, 2013.

In early November 2013, it is documented that the Resident #01 was complaining more frequently of increasing pain to the leg and hip and requiring more prn medication for pain control.

On a specific date in November 2013, the resident was re-assessed by the physician and prescribed a x-ray. The x-ray was done on a specific date in November 2013.

On a specific date in November 2013, the result of the leg x-ray indicated a fracture.

On a specific date in November 2013, the resident was transferred to the hospital for further assessment.

On a specific date in November 2013, the resident returned from the hospital with a leg cast.

On December 5, 2013, inspector reviewed the Resident #01 care plan last revised in September 2013. The care plan intervention section "turning and repositioning" indicates " ensure that the resident is well positioned when sitting in the chair".

The Registered Nurse S#001 was interviewed and stated that the Resident #01 upon the return from the hospital was not to be transferred out of bed due to the resident cast in order to maintain the alignment.

The RN S#001 confirmed that the care plan had not been revised since the resident's return from the hospital.

The home did not review the plan of care when the resident's care needs changed. [s.

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6 (10) (b) in t

Issued on this 12th day of December, 2013

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