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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_289550_0037	029658-16	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

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

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

JOANNE HENRIE (550)

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): October 12, 13 and 14, 2016.

This Critical Incident Inspection is related to a critical incident the home submitted related to the allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Registered Nurse (RN), several Personal Support Workers (PSW), and a resident.

The inspector reviewed a resident's health care records, a critical incident report, the home's abuse policy and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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). 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 is provided to the resident as specified in the plan.

The licensee submitted a Critical Incident (CIS) report to the Director on a specific date in 2016, reporting an incident of staff to resident physical abuse. Because of suspicious bruising on the arms and hands of resident #001, the Administrator had installed a hidden camera in this resident's room on a specific date in 2016. While reviewing the video on the camera four days later, she observed that a male PSW transferred resident #001 to the bed with the use of the mechanical lift and undressed the resident on his own. The Administrator identified the staff member as PSW #101. On October 12, 2016, Inspector #550 reviewed the video in the presence of the Administrator and observed the same. The Administrator indicated that resident #001 is a two person mechanical lift transfer.

The inspector reviewed the resident's plan of care dated a specific date in 2016 and observed the following documentation:
Transferring: total mechanical lift
Dressing/undressing: specific interventions related to specific behaviours.

During an interview, PSW #102 who is also the Behaviour Supports Ontario (BSO) staff indicated to the inspector that resident #001 requires specific interventions during care at all times because of specific behaviours. She also indicated that the resident requires to be transferred with the mechanical lift and the assistance of two staffs as per the home's mechanical lift policy. PSW# 103 indicated the resident requires specific interventions for care due to specific behaviours and he/she is a mechanical lift transfer with two staff. PSW #104 also indicated to the inspector that the resident requires to be transferred with the mechanical lift with the assistance of two staff members and that he/she usually requires specific interventions for care because of specific behaviours.

The Administrator indicated to the inspector that the home's mechanical lift transfer policy is that all mechanical lift transfers are to be done by two staff members at all times for staff and resident's safety.

A evidenced above, the care set out in the plan of care was not provided to resident #001 as specified in his/her plan. [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 resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff uses safe transferring and positioning devices or techniques when assisting residents.

Because of suspicious bruising on the arms and hands of resident #001, the Administrator had installed a hidden camera in this resident's room on a specific date in 2016 and later observed on the footage of the camera, that a male PSW transferred resident #001 without the use of a mechanical lift although the resident's care plan indicated the resident required to be transferred with the use of a mechanical lift.

Inspector #550 viewed the video with the Administrator and observed a male PSW transferring the resident from the bed to the wheelchair without the use of the mechanical lift. The male PSW was observed holding the resident by the back of his/her shoulders and knees and swing him/her so the resident was lying horizontally across the bed. The PSW then grabbed the resident by the left arm, and pulled him/her to a sitting position on the bed. He was then observed grabbing the resident by both upper arms and lifting the resident from the bed to the wheelchair on his own. The PSW was identified by the Administrator as being PSW #100.

During an interview with the Administrator in the presence of the inspector, PSW #100 indicated that resident #001requires to be transferred with the use of a mechanical lift as it is indicated on the pictogram placed on the wall above the resident's bed. The PSW indicated he did not know why he transferred resident #001 on his own without the use of the mechanical lift. He further indicated that this was not a safe transfer for the resident.

As evidenced above, PSW #100 was not using safe transferring techniques when assisting resident #001. [s. 36.]

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 staff uses safe transferring and positioning techniques when assisting resident #001,, to be implemented voluntarily.

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.