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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2018	2018_619550_0014	011664-18	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): August 27, 28, 29, and 30, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Care (PMRC), the Program Manager of Personal Care (PMPC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), several Personal Support Workers (PSW) and a resident.

In addition, the inspector observed the care and services provided to a resident and staff and resident interaction and reviewed a resident's health care records and policies related to falls.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. (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 failed to ensure that the plan of care sets out clear directions to staff and others who provided direct care to resident #001.

This inspection is related to log # 011664-18.

A CIR (critical incident report) was submitted to the Director reporting the fall of a resident which resulted in possible injuries. It was reported that resident #001 was left unattended in a specific situation and fell. Diagnostic testing revealed a specified injury. It was also documented on the CIR that resident #001 had sustained multiple falls in an identified six month period.

The progress notes were reviewed by inspector #550 and the inspector noted there were multiple falls documented in the progress notes in the identified period.

The PMRC #100 told inspector #550 that the residents' plan of care included the kardex as the care plans are kept in the electronic records which PSWs do not have access to. A kardex is available to them in a binder at the nursing station as well as in the residents' bathroom. The resident's risk for falls and interventions are documented in the kardex.

RN #101 told the inspector that resident #001 was at high risk for falls and had fallen often in the past months. The residents risk for falls and interventions are documented in their care plan in the electronic records and on the kardex and a copy is kept in a binder at the nursing station and in the resident's washroom. The kardex is the tool used by PSWs to guide them in the provision of care for a resident as they do not have access to the electronic records. PSW #104 told inspector #550 that they regularly cared for resident #001 and that the resident was known to fall often and had sustained a fracture in the past. They indicated that at the time of the reported fall, this resident required the assistance of two staff for a specific activity of daily living and was not to be left alone as the resident still thought they were able to walk and would get up on their own and fall.

The inspector reviewed the current kardex for resident #001 located in the binder at the nursing station with RN #101. The inspector observed that there was no documentation regarding this resident's risk for falls on the kardex. The inspector then reviewed the kardex in this resident's washroom and observed the resident's risk for falls was not documented on this kardex either. The inspector reviewed the kardex that was in place at the time of the resident's last and noted there was no documentation regarding the

resident's risk for falls or any intervention indicating this resident was not to be left unattended in a specific situations.

During an interview, PMRC #100 told inspector #550 the plan of care did not set out clear directions to staff and others who provide direct care to resident #001 as the kardex in place at the time of the last fall and the current kardex did not include the resident's risk for falls and the kardex in place at the time of the last fall did not indicate that the resident was not to be left unattended in a specific situation. [s. 6. (1) (c)]

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 plan of care for resident #001 sets out clear directions to staff and others who provide direct care this resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has specifically failed to ensure that any policy instituted or otherwise put in place is:
(b) complied with.

According to O. Reg. 79/10, s. 48. (1) 1., the licensee shall ensure that there is an

interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

This inspection is related to log # 011664-18.

A CIR (critical incident report) was submitted to the Director reporting the fall of a resident which resulted in possible injuries. It was reported that resident #001 was left unattended in a specific situation and fell. It was also documented on the CIR that resident #001 had sustained multiple falls in an identified six month period.

Inspector #550 reviewed resident #001's health care records including the documentation in the progress notes for the specified period. The inspector observed there were multiple falls documented. All the falls were unwitnessed, with no injuries to the resident except for the latest fall when the resident was diagnosed with a specified injury.

Program Manager for Resident Care (PMRC) #100 told inspector #550 that each time a resident has a fall, a post fall assessment is to be completed and documented in their electronic records. A neurological assessment is to be completed for each fall that are not witnessed or that results in a head injury. These assessments are to be completed and documented on a paper copy which are kept in the resident's chart.

The inspector reviewed the fall prevention program: fall risk assessment tool policy #315.08 and the assessment: head injury, policy #315.11, both with a revised date of September 2013. These two policies are part of the home's fall prevention program.
The fall prevention program: fall risk assessment tool policy indicated:
3. The registered staff has to complete the fall risk assessment tool when the condition of the resident or the situation requires it, such as:
-upon admission
-when the injury caused by the fall requires hospitalization
-when the resident has 2 or more falls within a week (7days).

The assessment: head injury policy #315.11 indicated:

Administrative practice:
Head injury assessment and neuro-checks shall be completed on residents with actual or suspected head injury for a period of 72 hours from time of injury, using the appended neurological assessment tool.

Operational procedure:
2. Monitor neuro status by completing the tool according to this schedule:
-hourly for 4 hours, then if stable,
-every 4 hours x 24 hours, then if stable,
-every shift x 2 days.

The inspector observed the appended document was form 315.11a: neurological flow sheet. Program Manager for Personal Care (PMPC) #106 told the inspector that an unwitnessed fall is considered a fall with a suspected head injury.

Inspector #550 reviewed the progress notes in the electronic records for resident #001 a specific period of time and noted there were multiple falls documented. All the falls were unwitnessed and with no injuries to the resident except for the latest fall. The inspector was not able to find a post fall assessment for three falls and a post fall assessment was initiated but not completed in full for six falls. The inspector reviewed the documentation in the resident's hard copy chart and was not able to find a neurological assessment for ten falls and a neurological assessment was initiated but not completed in full for seven falls. The inspector was not able to find documentation that a fall risk assessment had been conducted after resident #001 had more than two falls within a 7 day period which occurred once in the specified period of time.

Inspector #550 reviewed the post fall assessments and the neurological assessments for resident #001 with DOC #100. DOC indicated to the inspector that the two above policies which are part of their fall management program were not complied with as the post fall assessments and the neurological assessments were not completed after each fall. A fall risk assessment was not completed after resident #001 sustained more than two falls in a 7 day period. [s. 8. (1) (a),s. 8. (1) (b)]

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 policies that are part of the fall management program are complied with, to be implemented voluntarily.

WN #3: 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 the resident has fallen, the resident was assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

This inspection is related to log # 011664-18.

A CIR (critical incident report) was submitted to the Director reporting the fall of resident #001 which resulted in possible injuries to the resident. It was reported that resident #001 was left unattended in a specified situation and fell. It was also documented on the CIR that resident #001 had sustained multiple falls in an identified six month period.

Inspector #550 reviewed resident #001's health care records including the documentation in the progress notes for this identified period and observed there were multiple falls documented. All the falls were unwitnessed, with no injuries to the resident except for the last fall. The inspector was not able to find documentation indicating that a post fall assessment was completed for three falls and a post fall assessment was initiated but not completed in full for six falls.

Program Manager for Resident Care (PMRC) #100 told inspector #550 that each time a resident has a fall, a post fall assessment is to be completed and documented in their electronic records.

As evidenced, a post fall assessment was not completed for the identified documented falls. [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 falls, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was not neglected by staff.

This inspection is related to log # 011664-18.

O. Reg. 79/10, s.5 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CIR (critical incident report) was submitted to the Director reporting the fall of a resident which resulted in possible injuries to the resident. The resident had been left unattended in a specified situation and fell.

Resident #001's health care records including electronic documentation and hard copy chart were reviewed by inspector #550. It was documented in the progress notes that this resident had sustained multiple falls in an identified six month period. A progress note on the day of the latest fall indicated the resident was found on the floor after having been left unattended by PSW #102 and #103 in a specified situation. Upon assessment

the resident had complained of increasing pain to a specified body part. Diagnostic testing later revealed a specified injury to the resident. There was no documentation to indicate the resident had been complaining of pain the days prior to this fall.

During an interview, PSW #104 told inspector #550 that resident #001 was known for falling often. At the time of the last fall, resident #001 required the assistance of two staff for a specific activity of daily living and was not to be left alone as the resident still thought they were able to walk and would get up on their own and fall. RN #101 told the inspector this resident was at high risk for falling and fell often.

Resident #001 was interviewed by inspector #550. The resident was not able to tell or demonstrate to the inspector what to do to call staff for assistance. Resident #001 was not able to tell the inspector what the call bell was used for when the inspector showed them the call bell.

A review of interviews documented in the home's internal investigation file by PMRC #100 revealed that PSW #102 and PSW #103 were aware that resident #001 was at risk of falling. They told the PMRC they had placed a chair close to the resident in case the resident would attempt to get up on their own. PSW #103 indicated that they always left residents alone in a specified situation and gave them their call bell to call staff if needed; this was their current practice.

During an interview, PMRC #100 and Administrator #105 told the inspector both PSWs were aware that resident #001 was at risk for falls and that the resident was not able to use the call bell. PMRC #100 and Administrator #105 told the inspector they had determined through the home's internal investigation and interviews with the PSWs that PSW #102 and #103 had neglected resident #001 when they had left the resident unattended in a specified situation knowing the resident was at risk of falling and was not able to use the call bell.

Compliance Order #003 was previously issued on June 21, 2018 for s. 19. (1) during inspection #2018_548592_0008 with a compliance due date of September 28, 2018. This incident occurred prior to the compliance due date of the said Compliance Order. [s. 19. (1)]

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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

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.