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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2019	2019_618211_0009	029177-18	Complaint

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 1, 2, 3, 2019

During the course of this inspection the following log was inspected:
- Log #028496-18: related to alleged neglect from staff toward the resident's mouth care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager of Personal Care (PMOPC), Dietician, Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs) and the resident's Substitute Decision Maker (SDM).

During this inspection, the inspector reviewed the resident's health care records, several resident's flow sheets, licensee's investigation reports, a physician's order, a medication administration record (MAR), staff's scheduling, an annual dental assessment and several emails between the licensee and the resident's Substitute Decision Maker (SDM). During this inspection, the inspector observed the resident's room, bathroom and resident's meal time in the dining room.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

According to the O. Reg. 79/10 s. 34 (1) (a), the legislation indicates that every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) Mouth care in the morning and evening, including the cleaning of dentures.

Resident #004's SDM contacted the Ministry of Health Long-Term Care (MOHLTC) on an identified date, reporting that the resident's teeth were not brushed properly and this lack of care was previously expressed to the licensee.

Review of resident #004's plan of care on an identified date, indicated under the section titled "Activities of Daily Living" that the resident had their natural teeth and to provide mouth care. The resident's plan of care indicated to apply a small amount of dental paste on the toothbrush. Additionally, the resident's plan of care indicated to ensure that the resident's position was maintained a ninety degree angle and the resident's head is positioned forward to prevent suffocation.

In an interview with PSW #112 on an identified date, stated that the resident's teeth were brushed in the morning prior to breakfast and at bedtime. A small amount of dental paste was applied on the toothbrush before brushing resident's teeth. A towel was used to

remove the residual dental paste on the resident's teeth. PSW #112 stated that the resident was unable to rinse their mouth with water after the teeth were brushed. Afterward, the resident's teeth are cleaned a second time after breakfast but without dental paste. In an interview with PSW #116 on the next day, stated that the resident's teeth were brushed in bed prior to transferring the resident into the wheelchair for breakfast. A small amount of dental paste was applied to the wet toothbrush. While the resident rested flat in bed, the resident's teeth are brushed. The teeth are then wiped with a towel to remove the residual dental paste. The resident was able to swallow the rest of the dental paste.

In an interview with the DOC on an identified date, stated that the resident's plan of care did not indicate to brush resident's teeth in the morning and at bedtime. The resident's teeth should not be brush in a flat position in bed to prevent chocking.

The licensee has failed to ensure that there is a written plan of care that sets out clear directions to staff and others who provide mouth care for resident #004. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the following are documented:
1. The provision of care set out in the plan of care

Resident #004's Substitute Decision Maker (SDM) contacted the Ministry of Health Long-Term Care (MOHLTC) on an identified date, related to an incident that occurred two days prior the MOHLTC was contacted. The SDM reported that on an identified date, a broth was not offered to the resident during supper. The SDM was concerned that the resident could have developed dehydration.

Review of resident #004's sheet dated on an identified date and titled "Monitoring and Observation file MDS-Record of food and liquids" (Dossier de surveillance et d'observation MDS-Record d'alimentation et liquids) revealed that the amount of food and liquids consumed by resident #004 was not documented on specific shifts for four identified dates:

In an interview with the DOC on an identified date stated that the personnel support worker did not document the amount of food and liquids that was consumed by resident #004 on specific shifts for the four identified dates.

The licensee has failed to ensure that the provision of care set out in the plan of care related to the consummation of liquids and food were documented on the above days. [s.

6. (9) 1.]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident
-to ensure that the provision of care set out in the plan of care are documented, to be implemented voluntarily.

Issued on this 5th day of April, 2019

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

Original report signed by the inspector.