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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 5, 2019	2019_618211_0008	015683-18, 023140-18, 004296-19	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

JOELLE TAILLEFER (211)

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 26, 27, 28, 29, 2019 and April 1, 2, 3, 2019.

During the course of this inspection the following logs were inspected:
- Log #004296-19: Critical Incident Report (CIS) related to a fall and an injury which resulted in a significant change in the resident's health status.
- Log #015683-18: Critical Incident Report (CIS) related to an incident of alleged staff to resident abuse.
- Log #023140-18: Critical Incident Report (CIS) related to improper/incompetent treatment of a resident that results in harm or risk to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager of Personal Care (PMOPC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During this inspection, the inspector reviewed the residents' health care records, several resident's flow sheets, licensee's investigation reports, a physician's order, a medication administration record (MAR), post-fall assessment sheets, 24 hours report sheets and staff's scheduling.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition

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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her lifestyle and choices respected.

Review of the Critical Incident Report (CIS) submitted on an identified date, indicated RPN #107 was informed by resident #002 on the identified date, that PSW #109 pulled the resident's arms toward the chair.

Review of resident #002's progress notes on an identified date, indicated that when the resident arrived in an identified area, RPN #107 observed resident #002 crying. The resident informed RPN #107 that PSW #109 pulled them out of the bed by the arm to the bathroom". The progress notes indicated that there was no injury identified on the resident's arms.

In an interview with the Program Manager of Personal Care (PMOPC) on an identified date, stated an investigation of the incident was started immediately. On the identified date, the resident revealed not remembering the incident with PSW #109. The PMOPC reported that PSW #109 revealed that resident #002 was upset because the resident was told not to apply a specific product before meal. The PMOPC confirmed that PSW #109 did not respected the resident's choice.

The licensee has failed to ensure that resident #002's right of lifestyle and choice was respected when the resident wanted to apply the specific product prior going in the identified area. [s. 3. (1) 19.]

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 every resident has the right to have his or her lifestyle and choices respected, to be implemented voluntarily.

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. (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 was provided to the resident as specified in the plan.

Review of the Critical Incident Report (CIS) on an identified date, indicated the physician had ordered to remove resident #003's identified product on a specific date. The day before, during an identified shift, the resident's family member asked RN #110 to follow a specified procedure related to the resident's product every specific times. RN #110 explained to the resident's family member that this procedure was not included in the physician's order. RN #110 explained to the family member that a physician's order was required to proceed with the procedure for the resident's identified product. The next day, RN #110 returned to work and noticed that the procedure for the product was implemented.

Review of resident #003's progress notes on an identified date, indicated that the resident was experiencing a specific health condition and the identified product was installed as ordered by the physician. Two days later, the physician ordered to remove the resident's identified product on an identified date. One day before the removal of the product as ordered by the physician, during the identified shift, the resident's family member asked RPN #108 to execute a procedure for the resident's identified product. RPN #108 proceed with the procedure as requested by the family member.

In an interview with the Program Manager of Personal Care (PMOPC) on an identified date, indicated that during the investigation, RN #111 was informed by RPN #108 that a procedure for the resident's product was performed at the end of the identified shift on the specific date. RPN #108 advised RN #111 to follow a specific procedure related to the product every specific time as requested by the SDM. The PMOPC revealed that the resident's product was maintained in a specific manner for the entire shift. On the next shift, it was discovered by RN #110 that the other resident's specific product was wet, the identified product was still maintained in a specific manner creating an overflowed of the identified body fluid around the product.

In an interview with RN #110 on an identified date, stated that the resident was at risk to develop a specific medical condition since the product was maintained in a specific manner preventing the identified body fluid to drain. Therefore, the resident's identified body fluid had overflowed around the product. However, RN #110 revealed that the resident's condition was stable after performing a physical assessment. The resident's identified product was removed on the identified date as ordered by the physician

In an interview with the PMOPC on an identified date, stated that the registered staff were disciplined after the incident since they did not have the authorization from a physician to proceed with the procedure. Furthermore, the resident's was not monitored during the identiified shift. The PMOPC indicated that the registered staff was not authorized to proceed with the procedure and to follow the family requested without consulting with the physician.

The licensee has failed to ensure that the care set out in the physician's order was provided to the resident as prescribed in the 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 was provided to the resident as specified in the plan, 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.