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
May 21, 2019	2019_683126_0008	031897-18, 033171-18, 004334-19, 006374-19, 008016-19, 008957-19	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

LINDA HARKINS (126), LYNE DUCHESNE (117)

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): April 30, May 1, 2, 3, 7, 8, 2019

During the course of this inspection the following Critical Incidents were inspected:
Log # 031897-18: CIR #M511-000058-18, log # 006374-19: CIR # M511-000019-19 related to an allegation of neglect
Log # 033171-18: CIR #M511-000062-18 related to improper care/treatment
Log # 008957-19: CIR #M511-000025-19 related to environmental hazard
Log # 004334-19; CIR #M511-000010-19, log #008016-19 (CIR #M511-000022-10) related to related to a fall and an injury which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Program Manager of Personal Care (PMPC), the Program Manager of Resident Care (PMRC), two Physicians, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and several residents.

During this inspection, the inspector(s) reviewed several resident's health care records, observed several incidents, reviewed the licensee investigation notes and reviewed the following policies: Assessment: Head Injury # 315.11 (reviewed September 2018) and the Abuse and Neglect Policy #750.65 (reviewed June 2018).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **3 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	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 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. 1. The licensee has 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.

Related to log # 008016-19.
CIR (critical incident report) #M511-000022-19: Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status was reported to the Director.

Resident #001 had an unwitnessed fall on a specific day and was admitted to the hospital.

Discussion held with Program Manager of Personal Care (PMRC) #100 who indicated that each time a resident has a fall, a post fall assessment was to be completed and documented in their electronic records. The neurological assessment was 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 fall prevention program includes the Assessment: head injury, policy #315.11,

revised date of September 2018.

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 (Form 315. 11a).

Operational procedure:
2. "Monitor neurological 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.

Inspector #126 reviewed the progress notes in the electronic records for resident #001 for a specific time frame and noted that there were several falls documented.

A post fall assessment for the falls were documented for the falls. The inspector reviewed the documentation in the resident's hard copy chart and was able to find the neurological assessments for the falls that were initiated but not completed in full as per the policy.

Discussion held with Registered Practical Nurses #111 & #112 indicated that if the neuro watch were not documented that they were probably not done. RPN # 111 indicated that if the resident was sleeping, they would not wake them up specially if they are know to exhibit responsive behavior.

The licensee as failed to ensure that the Assessment: Head Injury which is part of the fall management program were not complied with as the neurological assessments were not completed after each fall.

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 head injury policy #315.11 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, shall immediately report the suspicion and the information to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. (Log # 031897-18)

A Critical Incident Report (CIR) (CIR # M511-000058-18) was submitted to the Director under the Long-term Care Homes Act, 2007, on a specific date in 2018. According to the CIR, Registered Nurse (RN) #118 was informed of the allegation of neglect.

RN #118 indicated to Inspector #126 that the Director was not notified immediately, that instead an email was sent to Program Manager of Personal Care (PMPC) #100 informing them of the allegation of neglect.

The licensee failed to ensure that the Director was informed immediately of the allegation of neglect. [s. 24. (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 a person who had reasonable grounds to suspect that any of the following has occurred or may occur, shall immediately report the suspicion and the information to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #3: 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 use safe transferring and positioning devices or techniques when assisting residents. (Log # 033171-18)

Resident #003 is identified as having decreased mobility issues, mobilizes with the aid of a wheelchair and requires transfer assistance. On a specific date in 2018, resident #003 had been drowsy during the day. During the evening meal, the resident was still drowsy and was unable to eat their evening meal. RPN #114 brought the resident to their room and transferred the resident from the wheelchair to the bed by themselves that resulted in a skin tear injury.

A review of the resident's plan of care at the time of the incident, identified that the resident required two (2) person side by side transfer assistance or a one person pivot transfer assistance, depending on the resident's tolerance and health status. As per the home's Administrator #102 and Director of Care of Personal Care #100 the resident was drowsy and should have had a two (2) person side by side transfer instead of a one person pivot transfer.

As such, RPN #114 did not use safe transferring techniques when assisting resident #003, resulting in a skin tear injury to the resident's left foot. [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 use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 24th day of May, 2019

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

Original report signed by the inspector.