

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report	
Report Issue Date: February 29, 2024	
Inspection Number: 2024-1537-0001	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: City of Ottawa	
Long Term Care Home and City: Centre d'Accueil Champlain, Vanier	
Lead Inspector Julienne NgoNloga (502)	Inspector Digital Signature Julienne Ngo Nloga <small>Digitally signed by Julienne Ngo Nloga Date: 2024.03.22 14:48:45 -04'00'</small>
Additional Inspector(s) Manon Nighbor (755)	

INSPECTION SUMMARY
The inspection occurred onsite on the following date(s): February 13, 14, 15, 16, 20, 21, 2024
The following intake(s) were inspected: Critical Incident System Report <ul style="list-style-type: none"> Intake: #00095699 - (CIS #M511-000028-23) - related to Infection Prevention and Control. Complaint <ul style="list-style-type: none"> Intake: #00102889 - related to an allegation of neglect of a resident. Follow-up <ul style="list-style-type: none"> Intake: #00104232 - related to Responsive Behaviours.

Ontario)

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410

Ottawa, ON, K1S 3J4

Telephone: (877) 779-5559

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were closed:

Order #001 from Inspection #2023-1537-0004 related to O. Reg. 246/22, s. 60 (a) inspected by Manon Nighbor (755)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services

Infection Prevention and Control

Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care Plan

NC #001 Written Notification pursuant to FLTCA 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

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.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary:

A resident had an identified medical condition and required a specified treatments three times weekly. Their care plan stated that every shift the resident was to be

Ontario)

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

provided an identified continence care and the outcome documented.

The specified home's policy #330.07 effective December 2005 and last revised May 2022, stated to document the quantity and quality of the identified continence care outcome. The policy did not include where to document the drainage.

A Charge Nurse (CN) confirmed that the above identified continence care was to be provided and its outcome documented every shift on the feuille de Supervision et Observations (feuille de route/flow sheets) and said that it was not always done.

There was no documentation on the flow sheets, or the progress notes indicating the outcome of the identified continence care for several shifts for multiple months.

Two nursing staff members confirmed that the outcome of the identified continence care was documented by the Personal Support Workers (PSW) on the flow sheets.

A staff member confirmed that they documented the outcome of the identified continence care on the flow sheets. They added that some staff members did not document if there was no outcome during the care.

As such, there was a significant lack of consistent documentation of the resident's above identified continence care.

Sources: Policy #330.07 Catheterization -Catheter Placement, Irrigation, Care & Removal; progress notes; feuille de route/flow sheets (feuille de Supervision et Observation). Interviews with four staff members.

[755]

Ontario)

**Inspection Report Under the
Fixing Long-Term Care Act, 2021**

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410

Ottawa, ON, K1S 3J4

Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Infection Prevention and Control

Program

NC #002 Written Notification pursuant to FLTCA 2021. s. 154 (1) 1.

Non-compliance with: 0. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s.102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. 0. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

A- Specifically, under the Infection Prevention and Control (IPAC) Standard: 9.1 where the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include hand hygiene, including, but not limited to, the four moments of hand hygiene.

Rationale and Summary:

A day in February 2024, three staff members had not performed hand hygiene as per minimum routine practices, infection prevention and control standards during lunch meal service and the provision of continence care to an identified resident respectively.

The identified resident had a specified medical condition. A signage at the resident's door indicated routine practices - additional contact, that directed staff to wear gloves, gown, and face mask.

The IPAC Lead acknowledged that all three staff members did not follow the

Ontario)

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

routine practices and additional precautions.

The failure to perform hand hygiene between residents' care placed residents at a moderate risk for cross-contamination.

Sources: Inspector's observations, review of a resident health record, and interviews with three staff members and IPAC Lead.

[502]

B- Specifically, under the Infection Prevention and Control (IPAC) Standard: 9.1 (f) where the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum, additional precautions shall include additional Personal Protective Equipment (PPE) requirements including appropriate selection application, removal, and disposal.

Rationale and Summary:

A day in February 2024, two staff members had not worn as per minimum additional PPE requirements, infection prevention and control standards during the provision of continence care to a resident.

The Resident had a specified medical condition. A signage at the resident's door indicated routine practices - additional contact and directed staff to wear gloves, gown, and face mask during direct care.

The IPAC Lead acknowledged that both PSWs did not follow the additional PPE requirements including appropriate selection application.

The failure to wear a gown during direct care placed other residents at a moderate risk for cross-contamination.

Ontario)

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410

Ottawa, ON, K1S 3J4

Telephone: (877) 779-5559

Sources: Inspector's observations, review of resident's health record, and interviews with two staff members, and IPAC Lead.

[502]