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

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Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1537-0003
Inspection Type: Complaint Critical Incident Follow up
Licensee: City of Ottawa
Long Term Care Home and City: Centre d'Accueil Champlain, Vanier

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16-25, 2024.

The following intake(s) were inspected:
Critical incidents (CI)

- Intake: #00116603 - CI#M511-000013-24 Resident to resident alleged abuse.
- Intake: #00121002 -CI# M511-000016-24 -Alleged improper/incompetent treatment of resident by staff.
- Intake: #00121571 -CI#M511-000021-24 - Related to staff to resident alleged abuse.
- Intake: #00123101 -CI# M511-000022-24 -Related to resident to resident alleged abuse.
- Intake: #00123157 -CI# M511-000023-24 -Alleged improper/Incompetent treatment of resident by staff.
- Intake: #00123499 -CI #M511-000026-24 -Alleged improper/Incompetent treatment of resident resulting in a fall.

Complaints

- Intake #00125589- A complaint with concerns to transfer equipment.

Follow up

- Intake: #00117815 – Follow-up#1 -Order #001/2024-1537-002; FLTCA, 2021 - s. 24- related to a resident-to-resident alleged abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1537-0002 related to FLTCA, 2021, s. 24 (1) inspected.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear direction to the staff and others who provided direct care to the resident. Specifically, with the supervision of the resident when they attended a scheduled appointment.

Sources: Inspectors observation, Resident interview, Interview with staff members, Resident Care Plan

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that the care set out in a resident plan of care was provided as specified in the plan. Specifically, the intervention set out in the plan of care were not followed for the alleged resident to resident abuse.

Sources: Resident's plan of care, interviews with staff members.

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident experiencing a change in health condition was reassessed and the plan of care was reviewed.

Sources: Resident progress notes, Interview with staff members.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that the Director was immediately informed of the alleged resident to resident abuse. The incident was only reported the next day.

Sources: Critical incident #M511-000022-24, interviews with Interview with staff members

WRITTEN NOTIFICATION: Policies

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 11 (1) (a)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and

The licensee has failed to implement their policy which stated that all resident appointments, transportations and accompaniment must be done by the family. On numerous occasions the licensee sent a staff to accompany a resident to their scheduled appointments.

Source: Review of Critical Incident System report, Resident Interview, Interview with staff members, Resident Progress Notes.

WRITTEN NOTIFICATION: Policies and Records

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure their policy titled: CIS Mandatory and Critical Incident reporting policy, and policy Maltraitance / Negligence was followed for an alleged resident to resident abuse. Specifically related to contacting the Ministry of Long-Term Care after hours reporting line and the Police.

Sources: Interview with staff members, review of licensee policies.

WRITTEN NOTIFICATION: Policies

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to comply and implement their policy on Lever et transfer des residents, which stated that their employees should receive mandatory education on safe lifts and transfers on orientation, annually and on demand. Staff members have only been receiving training during their initial orientations.

Sources: Home's policy, Interview with staff members.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. 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. O. Reg. 246 / 22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard 9.1 b) issued by the Director defined as: 9.1 the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident / resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident / resident environment contact; was followed by a staff.

The observations concluded that a staff did not perform hand hygiene during the snack service and did not support the residents to perform hand hygiene prior to receiving their snacks.

Source: Inspectors observations, Interview with staff members, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022 revised September 2023.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246 / 22, s. 105, 390 (2).

The licensee has failed to ensure that the police services were immediately notified of an alleged resident to resident abuse.

Sources: Review of Critical Incident #M511-000022-24, interviews with staff members, licensee investigation notes.