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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2013	2013_225126_0020	O-000498,000549,000550-13	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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)

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): September 12, 13, 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the two Director of Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Physiotherapist, the Rehabilitation Assistant and one Physiotherapist Assistant.

During the course of the inspection, the inspector(s) reviewed resident health care records, staffing schedules, the lift and transfer of resident policy #350.05 and the 24 hour nursing report.

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

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 failed to comply with O. Reg 79/10 s. 36 in that the home did not use safe transferring and positioning devices when assisting residents.

1) In the progress notes of a specified day in June 2013, it is noted that Resident #1 slid out of the transfer sling and hit his/her head on the floor. After the fall, the PSWs assisting Resident #1 indicated to the Evening Charge Nurse that they had been using a bed sheet and a lifting sheet to put under Resident #1 when they were transferring him/her to prevent him/her from sliding out of the sling. The following morning,the RN was informed about the accident and that the PSWs put bed sheet and a lifting sheet under Resident #1 to prevent him/her from falling. The day Registered Nurse,requested the Physio Assistant (PA) to reassess Resident #1 for a smaller type of sling. The PA assessed Resident #1 and determined that he/she required a smaller size of sling.

2)The resident health care record and the 24 hour nursing report were reviewed and it was noted in the 24 hour report that on a specified day in May 2013 that staff were to be careful when transferring Resident #1 because he/she slid down in his/her sling. Discussion with the Day Charge Nurse and the Assistant Rehabilitation and no documentation was found related to the reassessment of the resident size of sling or related to intervention to ensure safe transfer of the resident.

3) On the evening shift of September 12, 2013, just before supper, it was observed by Inspector #126, that two PSWs were going to transfer a resident with a sit to stand lift and had a green sling on top. When interviewed, they indicated that each resident has their own sling. When we verified the sling they had with the lift, it belonged to a resident that was transferred to another floor. When they went into the resident's room, the PSW's noticed that the resident did not have a sling in the bedroom. They initiated the transfer with the green sling that belong to the other resident. Inspector #126 found the sling that belonged to the resident in the laundry room. The resident's sling was noted to be a size yellow not green. The PSWs transferred the resident with the green sling not a yellow sling, therefore they transferred the resident with an incorrect size of sling.

4) On that same evening, discussion held with two other PSWs, as they were coming out of the room of another resident. It was noted by the Inspector #126 that, this resident did not have hid/her own sling in her room. They indicated they used the sling (green) that was on the mechanical lift knowing that it did not belong this resident. The

sling the PSWs used, was a sling that belonged to a resident that passed away.

4)The type of transfer for residents is indicated on small square piece of carton that is hung up on the wall at the head of the bed of the residents. There is no indication written for staff to identify with size of sling to use for residents in the residents bedrooms. PSWs indicated that resident does usually have their sling in the room and that it is the Nurse responsibility to choose the size. [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 the home use safe transferring and positioning devices when assisting residents which include the utilization of appropriate size and type of sling., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force 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. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 98 in that the licensee did not immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

On a specified day in June 2013, Resident #2 hit Resident #3 with his/her cane. Resident #3 sustained several bruises. The appropriate police force were not notified of this incident as of September 12, 2013 when the incident occurred on a specified day in June 2013.

Discussion with the Administrator on September 12, 2013 and she indicated that the Police were not notified of this incident. [s.98.]

Issued on this 26th day of September, 2013

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