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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2014_381592_0016	O-001364-14	Resident Quality Inspection

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

MELANIE SARRAZIN (592), HUMPHREY JACQUES (599), JOANNE HENRIE (550), LISA KLUKE (547), SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 22, 23, 24, 29, 30, 31 2014 and January 2nd, 2015.

During the course of the inspection, the inspector(s) spoke with The Administrator, One Director of Care, Manager of Food Services, Manager of Environmental Services, Manager of Maintenance, Activity Director, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, several Housekeeping staff, one Activity staff, several Dietary staff, the Administrator's assistant, the Program Clerk, the President of the Resident Council, the President of the Family Council, several Residents and several Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **4 VPC(s)**
- **1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, its furnishings are kept clean and sanitary in the second floor dining room.

On December 22, 2014 Inspector #547 observed walls and baseboards in the second floor dining room/activity room to be soiled with dried food and fluid matter. A set of curtains on the first window to the left of the main dining room were noted to have orange/brown dried food splatter embedded in the material in several areas. The door and wall outside the kitchen in this dining room also had several streaks of dried fluid and black marks on the door. The main dining room and activity room had dust and sticky grey matter embedded on the flooring around the base of the linoleum baseboards that was easily removed with inspector #547's nail when scratched. It was noted that the base of every table had white splatter, and food debris that had not been properly sanitized. The frame of the servery window to the kitchen was also noted to have dark brown debris in the edges and in the corners that had not been properly sanitized. Dried brown matter was also noted on this same servery window. These areas remained unchanged on December 31, 2014 during observation by Inspector #547.

On December 31, 2014, Inspector #547 interviewed Staff #118 regarding the home's expectations in keeping the dining room and activity room clean and sanitized. Staff #118 was aware of the areas in these rooms that had not been properly cleaned and sanitized, and indicated that these areas would be part of the complete cleaning of the room. This complete cleaning /Mode de Profondeur Hebdomadaire is part of the evening staff routine. Staff #118 indicated that staff communicate concerns to the Manager of Environmental Services with a narrative note on the back of the routine sheets for the week, and place the sheets in his mailbox every Monday morning and that the Environmental Manager was aware.

On December 31, 2014 Inspector #547 interviewed the home's Manager of Environmental Services who indicated that he had been made aware of the cleaning issues on the second floor by staff members. The Manager of Environmental Services provided Inspector #547 with a copy of the evening routine schedule, which indicated that the second floor dining room/activity room and kitchen-Bloc Alimentaire 2e. was to be conducted on Monday evening every week. The Manager of Environmental Services also provided Inspector #547 with a copy of the City of Ottawa policy and procedure for complete cleaning AP &OP No.420.05 last revised July 2014. The policy indicated that a complete clean is performed when a room gets an in-depth cleaning. Complete cleaning is performed once per week on all areas of the Home and signed for on the area routine sheets.

The Environmental Manager was not able to demonstrate that any of these routine sheets for the evening shifts had been returned to his office as required. The Environmental Manager further indicated that he has not conducted a formal audit in several months related to the cleaning in the home or any follow-up to these concerns. [s. 15. (2) (a)]

2. The licensee has failed to ensure that :
The home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c.8, s.15(2)(c). This is specifically related to the security systems in place at the front door and at the first floor staff room exit door.

On December 31, 2015, Inspector #550 observed that the exit door in the staff room leading outside to the parking lot of the building was closed but not locked. The door is equipped with a door access control card system; however, the Inspector did not use an access card to open the door at the time of the observation.

The staff room is located on the first floor and can be accessed by two different doors; one is from the main hallway of the West side of the building and the other access door is in the Veranda Dining room. These two access doors are kept closed, but not locked. As a result, the exit door within the staff room is always accessible to residents. The staff room exit door opens to the west side of the building, leading to the main entrance of the home and the main road. Inspector #592, accompanied by the home's Administrator, observed that the exit door in the staff room was not locked and that no audible door alarm system was activated when the door was held open. The Administrator indicated to Inspector #592 that the staff room exit door should be locked at all times, it should only

be opened by using the control card system and there should be an audible alarm if the door is open past a certain period of time. As well, if the exit door is opened without using the control card system, an alarm should sound immediately at the point of activation.

Later that day it was verified by inspector #592, in the presence of the Administrator, that the door access control card system had been repaired and the door was locked.

On December 31st, 2014, inspector #592 observed the main entrance door to be equipped with a door access control card system. The door was opened using the home's access card and was kept open for approximately 5 minutes. There was no audible alarm. Staff #112 and #113, who were at the reception desk, indicated they usually would receive a telephone call from the City of Ottawa Corporate Security Operations Center located off site. They did not receive a call. Inspector #592, accompanied by the Administrator opened the main door using the door access control card and held the door open for approximately 3 minutes and there was no audible alarm.

The Administrator indicated to inspector #592 that when a door is kept open for more than one minute:

-the alarm should sound at the 2nd floor nursing station where the alarm system is connected to the audio visual enunciator,
-all the pagers carried by staff on the second floor receive notification of an active door alarm.
- the Ottawa Corporate Security Operations Center located off site should immediately call to notify the home.

Later that day it was verified by inspector #592, in the presence of the Administrator, that the alarm system at the main entrance door had been repaired. An audible alarm sounded at the door when it was held open for a period of time.

As per. Reg 79/10, s. 9 (1)1.i and iii, resident accessible doors that lead to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, must be kept closed and locked and equipped with an audible door alarm. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. The licensee has failed to comply with O.Reg 79/10 s.8(1)b in that the written policies and procedures were not complied with.

In accordance with O.Reg 79/10 s. 131(6), Where a resident of the home is permitted to administer a drug himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,

(a) the use of the drug;
(b) the need for the drug;
(c) the need for monitoring and documentation of the use of the drug; and
(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7). O. Reg. 79/10, s. 131 (6)

The home's policy and procedures for Resident Self Administration Index number 03-04-10 was not complied with as evidenced by the following:

On December 29th 2014, inspector #592 observed in a resident's room on the bed side table the following prescribed medication:

One bottle of Azarga 1.0 % 1-2 drops in both eyes bid
One bottle of Loperamide 2mg 1 tab bid as needed.
Two bottles of Tears natural, I drop tid both eyes
Two bottles of Lumigan rc 0.01% I drop each eyes at bedtime.

During an interview with resident #02 on December 29th, 2014, he/she indicated to inspector #592 that he/she is capable managing his/her medication on his/her own and that he/she always leaves his/her medication on his/her bedside table in order to remind him/her to take them.

Upon a review of the Medisystem Pharmacy Policy for Resident Self Administration Index number 03-04-10 by inspector #592 on December 29th 2014, it is indicated that the Nurse and/or consultant pharmacist will perform a self-medication audit to assess the resident's ability to self-medicate as per facility policy. The assessment should ensure that the resident understands:
a. The use of the drug
b. The need for the drug
c. the potential side effect of the drug
d. the need for monitoring and documentation of the use of the drug; and the importance of keeping the drug safe and secure (if the resident is permitted to retain the their in their possession.

Upon a review of the physician orders on a specified day in October 2014, it is indicated that medication were prescribed as self-administration and to be kept at resident bed side.

Upon an interview with Staff #102 on December 29th 2014, he/she indicated to inspector #592 that he/she is aware that resident #02 has medication in his/her room for self-administration but indicated that he/she is not aware of the policy and the expectations from the home in regards to self-administration for medications.

Upon an interview with the Administrator on December 29th,2014, she indicated to inspector #592 that the home's expectation are that the resident who has the right to keep medications at bed side, should keep the prescribed medications in a locked drawer beside the bed. She further indicated that the resident should have an assessment in place to ensure that the resident is capable of doing the self-medication administration safely. Indicated to inspector #592 that she spoke with Registered Staff on the 3rd floor and they indicated that resident #02 is to keep his/her medications in his/her

personal belongings but often needs to be reminded by staff to not leave his/her medications on his/her bed side table. The Administrator further indicated to inspector #592 that she was unable to provide any assessment done for self-administration for resident #02. [s. 8. (1) (b)]

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 home's policy for Resident Self Administration is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

For the purpose of this report, the resident-staff communication and response system is often referred to as the call bell system.

On December 22 and 23, 2014 several inspectors observed the following:

-Room #215: call bell observed hanging on the bed frame underneath the bed, very close to the floor. (Inspector #550 on Dec 22, 2014 @13:41:16)
-Room #216: call bell in washroom rolled up on the towel rack on the left side of the toilet, unable to reach when sitting on toilet. (Inspector #550 on Dec 23, 2014 @ 12:15:53)
-Room #520: call bell cord in the resident's bathroom was hanging near the wall on the towel rack not within reach of the resident. Call bell cord near the resident's bed in room #520 was stuck behind the head board and not within reach while the resident is resting in bed. (Inspector #547 on Dec 23, 2014 @ 12:36:42)
-Room #514: call bell cord in the bathroom was hanging on the floor, not within reach of the resident. (Inspector #547 on Dec 23, 2014 @ 13:11:50)
-Room #509: call bell cord was noticed both December 22, and 23rd, 2014 to be attached to the left bed rail while in the down position, with the call button pointing to the floor, that was not easily accessed by anyone in this room. (Inspector #547 on Dec 23, 2014 @ 16:03:13)
-Room #302: call bell in bathroom was not within reach as it was located beside the sink on the left side. Inspector #592 was unable to reach the call bell when sitting on the toilet. (Inspector #592 on Dec 22, 2014 @ 13:36:05)
-Room #430: call bell in shared bathroom is not within reach (Inspector #546 on Dec 23, 2014 11:48:47).

During an interview, the Director of Care #101 indicated to Inspector #550 that it is the home's expectation that all call bells are accessible to all residents, staff and visitors at all times. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by residents.

On December 22, 2014 Inspector #547 observed on the 6th floor, a large sitting area near the elevator that is accessible to all residents. No call bell was observed in this sitting area or in any adjacent hallways.

On December 29, 2014 during an interview and an observation of the sitting area on the 6th floor, the Administrator indicated to Inspector #550 she was unable to locate a call bell in the sitting area. She indicated there should be a call bell in the sitting area as it is an area that is accessible to all residents and that she was under the impression there was a call bell there. [s. 17. (1) (e)]

3. The licensee has failed to ensure that if the resident-staff communication and response system uses sound to alert staff, is it properly calibrated so that the level of sound is audible to staff.

During an interview, the Administrator indicated to Inspector #550 the home uses two integrated systems to alert staff when a call bell is activated. They use an audible system and they also use the pager system. She indicated being aware of the Legislation regarding the communication and response system and that the home recently lowered the volume of the audible system in the hallways as some of the residents were complaining of the noise at night.

On December 29, 2014, Inspector #550 observed on the 3rd and 4th floor that when a call bell is activated, the audible system can only be heard when standing close to the nursing station and cannot be heard when standing in the hallway away from the nursing station. Inspector activated call bells in rooms #323, #334, #309 and #423 and could not hear the call bells when activated.

During an interview, RPN staff #102 indicated to Inspector #550 that when a call bell is activated, the audible system can only be heard from the nursing station and not in the hallways.

During an interview, PSWs staff #105, #106 and #107 indicated to Inspector #550 when a call bell is activated, the audible system cannot be heard in the Resident's room or in the hallway if not standing close to the nursing station. They rely on the pager system to inform them when a call bell is activated.

On December 29th, 2014, Inspector and PSW Staff #103 activated the call bell in resident room #323. The audible system could not be heard when standing outside of the room and the PSW's pager did not activate. After three attempts, PSW staff #103 went to change the battery in the pager and it worked well afterwards. [s. 17. (1) (g)]

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 resident-staff communication and response system is easily seen, accessed and used by the residents,staff and visitors and that the system is properly calibrated to be heard from hallways throughout the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labeled and are kept inaccessible to residents at all time.

On December 22nd and 30th, 2014 Inspectors #547 and #592 observed in a room, half can of powdered Comet with bleach located inside the resident's white cupboard with the door left open next to the toilet, accessible to the resident using this bathroom.

As per the product Material Safety Data Sheet, this product is classified under the Workplace Hazardous Materials Information System classification, as a Class D2A and D2B product. D2A is defined as very toxic material and D2B defined as toxic.

During an interview with Staff #108 on December 30th 2014, he/she indicated to inspector #592 that all hazardous products used for the cleaning and disinfecting of the home should be kept locked at all times in the housekeeping utility room. He/She indicated that Comet was not a product used by the home.
Staff #108 accompanied inspector #592 to the resident's room and indicated that the Comet did not belong to the home and that the home's expectation is that staff will report any hazardous products found in resident's room. Staff#108 contacted the Gestionnaire du service d'entretien who came to resident's room. He indicated to inspector #592 that the hazardous product should not as been in the resident's room and that this product could have been harmful to the resident in the room and other wandering resident. Comet was removed from room #520 by the Gestionnaire du service d'entretien.

Upon review of the Resident Health Care record, the resident had diagnosis of dementia mild Alzheimer's and it was indicated in the plan of care that resident was able to self-propel his/her wheelchair. [s. 91.]

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 all hazardous substances are inaccessible to residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that are administered to residents are in accordance with the directions for use specified by the prescriber r. 131. (2)

Upon review of two resident's Treatment Administration Record Sheets on December 29th 2014, it was noted that Resident #036 and #037 were to be provided prescription cream on a daily basis for the Month of December 2014.

The Physician's order dated on a specified day in December 2014 indicated the resident #036 was to continue with the application of the Canesten 1% to the affected area twice a day.

Upon review of resident #036 Treatment Administration Record Sheet, it was indicated that Canesten Cream was to be applied to affected area twice a day at 10:00 and 20:00 for the month of December 2014. Documentation was found for December 11th, 24th, 25th, 26th, 27th, 28th at 10:00 and the 30th at 10:00 and 20:00.

In an interview with PSW Staff #104 on December 29th 2014, he/she indicated to inspector #592 that Personal Support Workers are responsible for the application of prescribed topical cream. He/She further indicated that once the application of the cream is done they have to record it on their Treatment Administration Record Sheet located in a binder at the nursing station. Indicated to inspector #592 that he/she did not apply the prescribed cream for Resident #036 as he/she made the Registered Staff aware a few days ago that resident #036 redness was gone but does not recall to whom and when. He/She further indicated to inspector #592 that he/she is currently applying Cavillon cream to the area on a daily basis and not Canesten.

Upon review of Resident #037 Treatment Administration Record Sheet, it was noted that HC 2.5% in Glaxal Base was to be applied to the affected area's twice a day. There was no documentation to indicate it had been administered for the month of December 2014.

The Physician digiorder sheet dated on a specified day in October 2014 indicated staff to apply 2.5% HC Glaxal Base to the affected area's twice a day.

In an interview with PSW staff #103, on December 29th 2014, he/she indicated to inspector #592 that prescribed creams are given to the Personal Support Workers after the morning report and that the Cavillon cream for Resident #037 was only given to him/her by the Registered Staff this morning. He/She indicated that he/she did not apply the prescribed cream, only cavillon which does not need to be documented on the Treatment Administration Record Sheet. Further indicated to inspector #592 that often the Treatment Administration Record Sheet was not available for them in order to document their treatment.

On December 29th 2014, RPN Staff #102 indicated to inspector #592 that prescription creams are to be recorded on the Treatment Administration Record Sheet by the Personal Support Workers who are responsible for the application.

In an interview with the Administrator on December 29th 2014, she indicated to inspector #592 that the home has identified a problem with the recording of the documentation of the prescribed creams, therefore a new system was currently on trial on the 5th floor but not implemented on the other floors. Further indicated that the home is currently working on the policy for the Administration of Topical medication and that she did observe that some Treatment Administration Record Sheet were not documented. [s. 131. (2)]

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 drugs prescribed for Resident #036 and #037 are given in accordance with the prescriber, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that nursing staff involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other regarding Resident #034.

Upon reviewing the health care records for Resident #034, it was indicated that Resident #034 was admitted to the home on a specified month in 2013. Resident #034 was diagnosed with Alzheimers type dementia with responsive behaviours with staff related to personal care. It is also indicated that Resident #034 is followed by the Behavioural Supports Ontario team (BSO) in the home.

On December 23, 2014, Inspector #547 observed that Resident #034's right foot had very long toe nails. The Resident indicated to inspector #547 that it was bothering her/him, as his/her nails were too long and further indicated that he/she will cut his/her nails himself.
Upon reviewing the plan of care for Resident #034, it is indicated that the resident requires two staff assist related to behaviours, and is to receive nail care with baths which are offered twice a week.

Inspector #547 interviewed RN Staff #115 on the fifth floor on December 31, 2014 who indicated that Resident #034 often requires two person assist for personal care and further indicated not being aware that the resident's toe nails had not been trimmed during the month of December, 2014 as it was never communicated from the Non-Registered staff on the unit.

On December 31, 2014 Inspector #547 conducted a record review with the Director of

Care #101 of the resident's records and the Dossier de surveillance et d'observation MDS-BAIN flow sheet for the month of December, 2014 and observed that the resident had received baths twice a week and on two occasions, the resident had refused to have his/her nails cut. No other indication of any nail trimming was indicated on the flow sheet. Director of Care #101 indicated that the home's expectation is that when the boxes are left blank, it is considered not done and should have been reported to Registered Nursing staff.

On December 31st 2014, inspector #547 interviewed RN Staff #116 and he/she indicated that Resident #034 had moved to the 3rd floor on a specified date in 2014 and no communication from the fifth floor Registered Nursing staff regarding any issues or concerns of nail care for resident #034 was ever reported to him/her.

On January 2, 2015 the home's Administrator, located the Dossier de surveillance et d'observation MDS-BAIN flowsheets for the months of October and November 2014, which did not indicate any nail care provided to Resident #34 on his/her bath days for these two months. No communication was provided to shift report on the fifth floor during the last 3 months or recorded in the resident's progress notes.

Director of Care #101 further noted that Resident #34 has a pressure ulcer to his/her right leg requiring registered staff to provide wound care to this same foot, and no communication of any concern with the length of the resident's nails were noted in the resident's progress notes during these three months. Director of Care #101 indicated that RN Staff #116 attempted to trim the resident's nails, however they have become too thick and long to trim, and requires a foot care specialist referral. Director of Care #101 indicated that this resident would require specialized care planning regarding his/her nail care requirements and assist with the BSO team regarding specialized approach for this resident now that they have become aware of the resident's care needs. [s. 6. (4) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that weekly menus were communicated to residents.

On December 22 2014, inspector #547 noted that there was no weekly menu communicated on the second floor or on any other resident care unit.

On December 31, 2014 Inspector #547 interviewed the Food Services Manager for the home, who is contracted by Aramark. The Food Service Manager indicated she had removed the weekly menus from the resident care units at the beginning of December 2014, as a result of a directive given to her by Aramark. The Food Services Manager indicated that this direction from Aramark was not communicated to the home's Administrator. [s. 73. (1) 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized of housekeeping under clause 15(1)(a) of the Act, the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. O Reg.79/10, s. 87(2).

Specifically the Licensee has failed to ensure that offensive lingering odour is addressed in resident's room on the second floor, West wing and including the shared female shower room on the fifth floor East wing, despite routine cleaning.

Upon entering room #236, Inspector #546 observed on December 22, 2014 at 14:00 a strong odour of urine. There were no incontinence products left in the room; the bathroom and bedroom were both clean in appearance.

Inspector #547 observed on December 23, 2014 at 14:30 that the 5th floor woman's shower room had significant urine odour lingering, and areas in the grout and tiles inside the shower and around the toilet to have orange/black matter embedded.

On December 31, 2014, in an interview, Staff #118 informed inspector #599 there was a problem with room #236, with urine odour. The home attempted to clean the room which was not successful and an in-house employee was directed to clean the room with special equipment to brush the floor using a solution which improved the odor slightly. Staff #118 informed inspector #599 that this cleaning in room #236 was done about 8 months ago and that room #236 is cleaned as per routine which is a full clean once a week and a check clean on a daily basis.

On December 31, 2014, in an interview, the Environmental Manager indicated to inspector #599 that a detailed cleaning of rooms is done once a week, including visual check daily and cleaning of floors as required. Bathroom, shower rooms are cleaned as required with a deep clean once a week.
He further indicated that the Home treats odour at source, and if not successful with lingering odour; an odour neutralizer canister is installed.

On December 31, 2014, the Environmental Manager accompanied Inspector #599 to room #236 on the West wing of the second floor. There was a strong lingering odour in front of room #236 and the door was closed. On opening the door, there was a strong odour of urine present and the Environmental Manager indicated that there was a lingering odour problem with this room and it needed to be sorted out again. Inspector #599 observed that there was no odour neutralizer canister installed in room #236.

The Environmental Manager accompanied by inspector #599 went on a walk about to the female shower room on the East side of the 5th floor and the Environmental Manager observed that there was a strong odour present in the shower area. There was one tile which was cracked and some tiles were out of alignment around the base of the shower

cubicle. The grout was embedded with black/orange matter. The Environmental Manager indicated that there was a presence of a strong lingering odour and indicated that repairs needed to be done and the shower unit required a good cleaning to eliminate the offensive odour. [s.87 (2)] [s. 87. (2) (d)]

Issued on this 5th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE SARRAZIN (592), HUMPHREY JACQUES (599), JOANNE HENRIE (550), LISA KLUKE (547), SUSAN WENDT (546)
Inspection No. / No de l'inspection :	2014_381592_0016
Log No. / Registre no:	O-001364-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 5, 2015
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL CHAMPLAIN 275 PERRIER STREET, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LOUISE BOURDON

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement that door security systems are maintained in a good state of repair.

In addition, the home shall have a process in place to ensure that all resident accessible doors leading to the outside of the home are verified and monitored to ensure security systems are functional.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

This plan is to be submitted in writing to Long-Term Care Homes Inspector Melanie Sarrazin by February 20th 2015 via e-mail to melanie.sarrazin@ontario.ca

Grounds / Motifs :

1. The licensee has failed to ensure that :
The home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c.8, s.15(2)(c). This is specifically related to the security systems in place at the front door and at the first floor staff room exit door.

On December 31, 2015, Inspector #550 observed that the exit door in the staff

room leading outside to the parking lot of the building was closed but not locked. The door is equipped with a door access control card system; however, the Inspector did not use an access card to open the door at the time of the observation.

The staff room is located on the first floor and can be accessed by two different doors; one is from the main hallway of the West side of the building and the other access door is in the Veranda Dining room. These two access doors are kept closed, but not locked. As a result, the exit door within the staff room is always accessible to residents. The staff room exit door opens to the west side of the building, leading to the main entrance of the home and the main road. Inspector #592, accompanied by the home's Administrator, observed that the exit door in the staff room was not locked and that no audible door alarm system was activated when the door was held open. The Administrator indicated to Inspector #592 that the staff room exit door should be locked at all times, it should only be opened by using the control card system and there should be an audible alarm if the door is open past a certain period of time. As well, if the exit door is opened without using the control card system, an alarm should sound immediately at the point of activation.

Later that day it was verified by inspector #592, in the presence of the Administrator, that the door access control card system had been repaired and the door was locked.

On December 31st, 2014, inspector #592 observed the main entrance door to be equipped with a door access control card system. The door was opened using the home's access card and was kept open for approximately 5 minutes. There was no audible alarm. Staff #112 and #113, who were at the reception desk, indicated they usually would receive a telephone call from the City of Ottawa Corporate Security Operations Center located off site. They did not receive a call. Inspector #592, accompanied by the Administrator opened the main door using the door access control card and held the door open for approximately 3 minutes and there was no audible alarm.

The Administrator indicated to inspector #592 that when a door is kept open for more than one minute:

-the alarm should sound at the 2nd floor nursing station where the alarm system is connected to the audio visual enunciator,

-all the pagers carried by staff on the second floor receive notification of an active door alarm.
- the Ottawa Corporate Security Operations Center located off site should immediately call to notify the home.

Later that day it was verified by inspector #592, in the presence of the Administrator, that the alarm system at the main entrance door had been repaired. An audible alarm sounded at the door when it was held open for a period of time.

As per. Reg 79/10, s. 9 (1)1.i and iii, resident accessible doors that lead to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, must be kept closed and locked and equipped with an audible door alarm. (592)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Sarrazin

Service Area Office /
Bureau régional de services : Ottawa Service Area Office