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
Jun 12, 2015	2015_225126_0020	O-001160-14, 001524-15, 001665-15, 001221-14, 001248-14, 000410-14	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): June 3, 4, 5, 8, 9, 10, 2015

During this inspection six Critical Incidents were reviewed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the two Resident Care Managers(Nursing, Personal Home Support Worker), several Registered Nurses, several Registered Practical Nurses, several Personal Support workers and several residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #05 and Resident #06.

On a specific date in February 2015, Resident #05 exhibited sexual behaviors toward Resident #06. The Home notified the physician, completed a referral to the Psycho Geriatric Team and implemented 1:1 supervision for Resident #05. Resident #05 medications were reassessed and changed as per needs on an ongoing basis for several months. A family conference was held with the families of both residents. It was discussed and accepted by both families that it was acceptable for Resident #05 and Resident #06 to be together in an "affectionate matter".

Discussion held with Registered Nurse S #102 who defined "affectionate matter" as walking together, holding hands, kissing on the cheeks.... and defined sexual behaviors as for example: foundling her breast, touching the genital areas.... If sexual behaviors would be exhibited, those behaviors would not be accepted and both residents would be separated.

Several staffs on the unit were interviewed during the inspection and they could not give a clear definition of what is “affectionate matter” on what is acceptable or not. Registered Nurse(RN) S #102 indicated that all staff should have been aware because it was explained to them at report.

Registered Practical Nurse (RPN) S #100 and RN S #102 could not find the written care plan that set out clear directions to the staff on what was “in an affectionate matter and what type of behaviors would be acceptable or not.

The licensee has failed to ensure that the plan of care for Resident #07 and Resident #08 set out clear directions to staff.

On a specific date in October 2015 Resident #08 slapped Resident #07 on the face which resulted in some redness to the left eye. Both Residents progress notes were reviewed for the period of approximately 4 months. It was noted that there were five incidents between those residents and two resulted in resident sustaining an injury. The plan of care was reviewed for that period and there was no written plan of care identifying that Resident #07 and Resident #08 could potentially demonstrate responsive behaviors when they were within close proximity. [s. 6. (1) (c)]

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 the written plan of care set out clear direction to staff and others who provide direct care to Resident #05, #06, #07 and # 08., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policy that promotes zero tolerance of abuse and neglect of was complied with.

The licensee does have a written policy "Acknowledgement & understanding of prevention of Abuse Policy (# 750.65)". In the policy, under section Operational Procedure, staff are required to:
"1. Report immediately any suspicion of allegation of resident abuse to the Charge Nurse. Definition of abuse as per LTCHA and appendix A.
4. Immediately report the allegation to the Administrator and Manager of Resident Care.
7. The Administrator or delegate must immediately notify:
-The Ottawa Police if it is believed that the incident constitutes a criminal offense.
-The Ministry of Health and Term Care refer to decision tree.
8. Manager of resident Care or designate will complete a Critical Incident report."

1)In the evening of a specific date in October 2014, Resident #01 exhibited sexual behaviors toward Resident #02. The incident was reported to the Resident Care

Manager S# 110 two days later.

On June 4th, 2014, Inspector #126 interviewed Resident Care Manager S# 110 regarding this incident. She indicated that the Critical Incident report was submitted as soon as she became aware. She reviewed her email to ensure nothing was sent to the Ministry and did not find any notification to the Ministry of that specific incident.

On June 4th, 2014, Inspector #126 interviewed the Administrator, who indicated that the expectation is that the nursing staff in charge would call the Administrator or the delegate after hours if there is a potential or actual incident of abuse. The Administrator indicated that once Management received the call, it is their responsibility to notify "CIATT". The Administrator indicated that she was aware that the incident that occurred on a specific date in October 2014 was not immediately reported to the Ministry.

The potential/actual incident of abuse was not immediately reported to the Administrator or the delegate as per the home's policy requirement.

2)On two specific days in February 2015, Resident #05 exhibited sexual behaviors toward Resident #06. Both incidents were discussed with the Resident Care Manager S# 110 three days after the last incident, which at that time a Critical Incident was initiated.

The potential/actual incident of abuse was not immediately reported to the Administrator or the delegate as per the home's policy requirement.

3)On a specific date in October 2014,an incident of physical abuse occurred between Resident #07 and Resident #08. RN staff #103 sent an email to the Director of Care and to the Administrator to inform them of the incident of abuse. The policy of the Home requires staff to notify the Administrator or delegate immediately for any allegation of abuse.

On June 9, 2015, Inspector #126 interviewed the Resident Care Manager S# 110 regarding the incident of October 2014. S# 110 reviewed the email received regarding the incident and indicated that the email of this incident was sent to herself and the Administrator and was not sent to the Ministry (CIATT). The Critical Incident was sent to the Ministry the following day.

The potential/actual incident of abuse was not immediately reported to the Administrator or the delegate as per the home's policy requirement.

4)The licensee has failed to ensure that when Resident #11 complained about the care received by the night PSW in April 2014 that the nursing staff did not report immediately the potential/actual abuse or neglect to the Resident Care Manager.The policy requires any staff to report any suspected/ allegation of abuse to be immediately reported to the Charge Nurse.

In reviewing Resident #11 documentation related to the incident of potential physical abuse, it was noted that in an email dated a specific day in April 2014 sent to the Resident Care Manager S #111 by RN S #112, that Registered Practical Nurse (RPN) S #108 informed S#112 that Resident #11 complained about that PSW the previous week and that RPN S#109 confirmed that the resident complained on several occasions.

Some nursing staff were aware of the concerns of Resident #11 did not immediately notify the Charge Nurse and did not follow up on his/her concerns. Resident #11 concerns were brought forward by a family member to the Administrator on a specific day in April 2014. It was noted that the PSW that was reported by Resident #11 was not working for 5 days after the incidents and was suspended an extra 8 days in April 2014. [s. 20. (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 staff understand the requirement of the policy related to reporting, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home are dressed appropriately, suitable for the time of the day and in keeping with his or her preferences.

On June 6, 2015, Inspector #126 observed Residents #10, #12, #13, #14 and #15 to be in their pyjamas at 16:30 hours.

On June 9, 2015 Inspector #126 observed Residents #7, #10, #12, #14, #15, #16, #17, #18 and #19, to be in their pyjamas at 17:25 hours having dinner in the dining room. Inspector #126 discussed these observations with Registered Nurse(RN) S #103 who indicated she was not sure of the reason why these residents were in pyjamas at that time. S #103 suggested asking Personal Support Worker(PSW) S #105. S #105 indicated that Resident #16 was in his/her pyjama because he/she was wet and it was difficult to dress him/her and that Resident #12 just had her bath. PSW S #106 came forward and indicated that several of these residents were assigned to her and because she works from 16:00-20:00 hours, she put residents in their pyjamas before supper as she does not have enough time to put them in pyjamas after supper.

The written care plans of the residents observed on June 9, 2015 were reviewed and no documentation was found that it is the resident's preferences to be in their pyjamas before or during supper time. [s. 40.]

Issued on this 25th day of June, 2015

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

Original report signed by the inspector.