Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 23, 24, Nov 2, 27, 2012	2012_203126_0004	Critical Incident

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 inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care,the Coordinator of Best Practices, several registered nursing staff, several personal support workers and several residents.

During the course of the inspection, the inspector(s) reviewed two residents health care records, reviewed the skin and wound care program policies #315.12, #355.12.

Several Critical Incidents were reviewed during this inspection.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, Chapter 8 s. 24(1)1. in that the the licensee had reasonable grounds to suspect an incident of improper care of a resident occurred and that resulted in harm of the resident was not immediately report to the Director.

In April 2012, a Personal Support Worker pulled her/his hand way from the resident hands and caused a laceration to the hand of the resident. The registered nursing staff did not report this incident to the Coordinator of Best Practices or to the Director of Care. The incident occurred on April 5, 2012 and was reported to the Director on April 13, 2012, eight days after the incident occurred.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s.50. (2)(b)(i) in that a resident that was exhibiting a skin tear did not received an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

In April 2012, a Personal Support Worker pulled her/his hand away from the resident and the resident sustained a skin tear on the top her/his right hand. The resident health care record (progress note, Medication Administration Record Sheet (MARS), care plan) was reviewed for April 2012 and no documentation was found related to assessment and monitoring of the skin tear.
Discussion held with several registered nursing staff and they indicated that a dressing was applied to the skin tear and that they did not used a clinically appropriate assessment instrument to document the skin tear of the resident.

The licensee failed to comply with O. Reg 79/10 s.50.(2)(b)(iv) in that a resident exhibiting altered skin integrity such as a skin tear was not reassessed at least weekly by a member of the registered nursing staff.
Discussion with the registered nursing staff on the unit and they indicated that for a skin tear they don't always document the skin tear on the MARS because they apply a dressing on and let the skin tear heal on it's own.
As per the Home policy and procedure #355.29 ("Soins de la peau et des plaies: Outil d'evaluation des plaies et de la peau") it is expected that the nursing staff document on the "Outil d'evaluation de la peau ou Outil d'evaluation des plaies" if altered skin integrity is noted and that an assessment shall be done by a registered nursing staff at least once a week or as per physician order until healed.

Discussion with the Director of Care and she indicated that if any resident as altered skin integrity that it should be documented on the MARS. April 2012 MARS, was reviewed and no documentation was noted related to the resident's skin tear.

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers , skin tears or wound,receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment tool and that is reassessed at least weekly by a member of a registered staff,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s.107. (1) in that the Director was not notified immediately of an outbreak of a reportable disease or communicable disease as define in the Health Protection and Promotion Act.
A respiratory outbreak was declared in the home on March 13, 2012 and the Director was notified on March 19, 2012 , 6 days later.

2. The licensee has failed to comply with O. Reg 79/10, s.107. (3) in that the Director was not notified no later than one business day after an injury in respect of which a person is taken to hospital.
In March 2012, a resident had a fall and was sent to the hospital. The Director was notified 7 days after the incident occurred.

Issued on this 28th day of November, 2012

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