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

Division de la responsabilisation et de la performance du système de santé
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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, 25, 26, Nov 27, 28, 2012	2012_203126_0005	Complaint

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 Complaint 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 three residents health care records, reviewed the head injury policy "MSSLD 0909-01".

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

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. 6. Plan of care

Specifically failed to comply with the following subsections:

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,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, ch 8, s.6.(10) (b) in that the home did not review the plan of care when the resident's care needs change.

A Resident fell in September 2012 and sustained a bruise on her/his forehead and a laceration above her/his eye and the head injury protocol was initiated. The head injury care plan under nursing diagnosis "Danger. Chute. Traumatisme cranien" interventions requires vital signs and neurological evaluation every 2 hrs for 72 hours and to document on every shift for 3 days.

The home did not review and follow the plan of care when the resident's care needs changed. Residents vitals signs and neurological evaluation were not found in the resident health care record for the night shift of September 25 and 26, 2012. The nursing staff did not document any progress notes for day and evening shift for September 25, 2012.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 r.49. (2) in that the resident had two falls and a post-fall assessment were not conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident fell twice in September 2012 and no post fall assessments were found in the resident's health care record.

Discussion with the Director of care and she indicated that the Licensee had developed a post fall assessment tool that was going to be implemented in the future.

Issued on this 28th day of November, 2012

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