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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Apr 1, 2016	2016_381592_0006	025575-15	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

MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 2, 3 and 4, 2016

This complaint inspection is related to resident care services

During the course of the inspection, the inspector(s) spoke with the Administrator, one Gestionnaire de Programme de Soins aux Residants, Registered nursing staff members (RN and RPN), Personal Support Workers (PSW) and one family member. The inspector reviewed resident health care records, home internal investigation process and observed resident/staff interaction and resident care.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute decision maker

(SDM), if any, and the designate of the resident / SDM are provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #001 is identified as having several medical conditions including arthritis, osteoporosis, dementia and diabetes. A review of the resident plan of care, dated on a specific day in July 2015, indicates that the resident is walking with the assistance of a walker and is totally independent when wandering on the unit. It further indicates that the resident is transferring on his/her own with no supervision required and is known to wander all day long on the unit with his/her walker.

On a specific day in September 2015, resident #001 was observed to have difficulty mobilizing on the unit and was complaining of having pain to a specific body part. Resident #001 was assessed by RN #102 and was provided with analgesics. The resident was seated in a wheelchair for the day and evening to promote comfort, with no further expressions of discomfort.

On the following day, at a specific time, the resident health care records indicate that resident #001 was identified by the night registered staff member, as having a general deterioration of his/her physical functions as is not able to use a specific body part and requiring the assistance of two staff members for his/her transfers. The progress notes further indicate that resident #001 was unable to walk and was seated in a wheelchair with no further expressions of discomfort.

Later on that day, at a specific time, resident #001 health records indicate that RN #104 who was covering for the day, contacted the physician due to the elevation and fluctuation of the resident's blood sugar and due to the resident complaining of being thirsty and being warm to touch. The physician ordered that an extra dose of insulin be administered to the resident. The physician also requested that nursing staff contact him 2 hour post insulin administration for an update on the resident's status. The progress notes indicate that the blood sugar had decreased and that the physician was contacted back with an update of the resident's status 2 hours later. Instructions were left to RN #104 to keep monitoring the resident and to contact him (physician) in an hour.

On that same day, during the evening, the resident health records indicate that resident #01 demonstrated a change in behaviours, was more resistive to care with a deterioration of his/her general condition and a urine specimen was obtained by RN #104. It is documented that the results of the urine sample was positive for a potential urinary tract infection. It further indicate that resident #001 blood sugars continued to be

elevated and that the physician was contacted by RN #104. Antibiotic therapy was prescribed by the physician and insulin was also prescribed to decrease resident #001's blood sugar.

On the following day, the resident health care records indicate that resident #001's general health status had declined. The records further indicates that RN #102 observed resident #001 to be more resistive to care, with increased agitation. It is also noted that the resident had not been able to weight-bare for the past 2 days. The resident health care records further indicate that RN #102 discovered a large bruise on a specific body part and that the body part was warm to touch. It is documented that following the observations, that RN #102 contacted the resident #001's SDM to inform him/her about the medical concerns, and resident #001's decline in the health status. It further indicate in the resident health care records, that upon the family member's arrival on that same day, the SDM inquired to RN #102 why he/she had not been informed of all the medical concerns and the new treatments for resident #001. It is documented that RN #102 apologized for the staff members who worked on the previous days for not being contacted before today.

The following day, resident #001 was transferred to the hospital with the approval of the SDM following the physician recommendations. In hospital, the resident was assessed and diagnosed with a fractured of a body part.

On March 3, 2016, in an interview with RN #102, she told inspector #592 that the home's expectations is that family members need to be contacted when there is a significant change in condition, such as the declining of the condition, infection, change of medications, behaviours and any change in the resident routine. She further told inspector #592 that she realized being the first staff member notifying the SDM, as she was told by the SDM that he/she had not been contacted for the deterioration of the condition, the new medications, fluctuation of blood sugars and change in resident #001's routine prior to the staff call.

On March 3, 2016, in a phone interview with RN #104, he told inspector #592 that he does not recall having contacted the SDM about the deterioration of resident #001's condition, including the new medication ordered by the physician.

On March 3, 2016 in an interview with the "Gestionnaire de programme de soins aux residants" #106, she told inspector #592 that following the home's internal investigation,

it was confirmed that nursing staff did not contact the SDM when there was a decline in Resident #01 health status. She also confirmed that the SDM was not contacted regarding changes in the resident's medication. The Gestionnaire de programme de soins aux residants confirmed to the inspector, that it is the home's expectation that nursing staff members contact resident families when there is a change in the resident's condition and medical treatments.

The SDM was not made aware of the medical concerns and the declining status of Resident #001 until 2 days after, therefore, SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care for Resident #001. [s. 6. (5)]

Issued on this 1st day of April, 2016

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

Original report signed by the inspector.