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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 16, 2016	2016_285126_0010	012462-16	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

LINDA HARKINS (126), JOANNE HENRIE (550), JOELLE TAILLEFER (211), MELANIE SARRAZIN (592)

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): May 24-June 10, 2016

During the inspection four critical incidents related to alleged abuse, three critical incidents related to incident that caused an injury and resident was transferred to hospital and two complaints related to resident care inspections were conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Managers of residents care (Registered Staff and Personal support Workers),the Environmental Services Manager, the Registered Dietitian, the Social Worker, the Food Service Manager, the Activity Director, several Registered Nurses, several Personal Support Workers, four Dietary Aids, two Activity staff, Resident Council President, Family Council Co-Presidents, resident and family members.

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

During the course of this inspection, Non-Compliances were issued.

12 WN(s)
6 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).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 the resident.

Inspector #550 observed resident #008 on May 26 and June 1, 2016 sitting in the wheelchair with a lap belt applied. The resident was unable to release the belt due to cognitive deficit.

The inspector reviewed the resident's health care records. It was documented in the progress notes by the Occupational Therapist on a specific date in April 2016 that resident #008 was assessed and a tilt wheelchair with a lap belt was ordered to maintain neutral pelvic position. According to the notes, the chair was delivered the following week. Inspector reviewed the resident's plan of care in place at that time and the actual plan of care and was unable to find any directions regarding the lap belt and the tilt wheelchair for resident #008.

During an interview, RN S#122 indicated to the inspector that the resident does not need the lap belt when sitting in the wheelchair. She indicated that when the resident received the custom made wheelchair, he/she was seated properly and was no longer sliding in the chair. Since the lap belt was not needed, it was not added to the resident's plan of care. She further indicated that because the lap belt is still attached to the wheelchair, staff automatically applies it.

As evidenced above, resident #008's plan of care does not provide clear directions related to the application of the lap belt , to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. 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.

This finding is related to log # 031379-15:

Resident #049 is identified as having several medical conditions.

A review of the resident plan of care, indicates that the resident is totally depending on staff for his/her personal care and that the resident is transferring with the assistance of two staff members and the use of a lift. Resident #049 is also followed by the geriatric team for behaviours.

A review of the resident progress notes indicates that on a specific date in October 2015, resident #049 was complaining of pain to one specific area of the body and was provided with some analgesics. An assessment was completed and there was no redness, no oedema, no warmness to touch and that a close monitoring would be done.

On a specific date in October, 2015, resident #049 was observed with a bruise measuring 5 centimeters from unknown origin with pain to touch and nausea. Analgesic was provided and the home physician was contacted and requested to have mobile x ray.

Two days later, resident #049 had x ray taken.

Two days after the x ray was taken, resident #049 was diagnosed with a fractured.

At approximately one hour later, it is documented that the resident #049's SDM was contacted and was informed of the x ray result. It further indicate in the resident health care records, that the SDM inquired why he/she had not been informed of the x-ray done on a specific day of October 2015 and requested to have the physician to contact the family back upon his next visit to the home.

It is documented in a late entry for a specific date in October 2015, that two family members were at the home site, including the SDM and inquired to RN #131 why they were not informed when they visited, when the pain and the bruising were observed on resident #049 and also about the requested x-ray by the physician. It is further documented that the family had voiced some concerns to RN #131, regarding the fracture and the potential of a physical abuse. It is documented that RN #131 would report their voiced concern to her manager.

On June 07, 2016, in an interview with RN #131, 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, fall, transfer to hospital, sudden pain, medication error, injury, bruising, skin tear or if any request of test for a resident. She further told Inspector #592 that for resident #049, the SDM should have been contacted on that specific day of October 2015 when the registered staff discovered the new bruising and that a possible fracture was suspected.

On June 07, 2016, in an interview with the Resident Care Manager (RCM) # 137, she told inspector #592 that it is the home's expectation that nursing staff members contact the resident family members when there is a change in the resident's condition and medical treatments.

The SDM was not made aware of the medical concerns of resident #049 until 4 days after, therefore, SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care for Resident #049. [s. 6. (5)]

3. The licensee has failed to ensure that the following are documented:

1. The provision of the care set out in the plan of care.

During a review of resident #001's health care records, Inspector #550 observed that the

resident was scheduled to receive a bath on May 5, 7, 10, 14, 17, 21, 24 and 28, 2016. It was observed in the resident's flow sheet "Dossier de surveillance et d'observation MDS - bain" that there was no documentation to indicate that the resident received a bath as scheduled on May 7, 17, 21 and 24.

During an interview, the Resident Care Manager #121 indicated to the inspector after conducting an investigation with the concerned PSWs for the above dates, that the resident did receive her bath as per the established schedule and that it was not documented by the PSWs.

As evidenced above, the provision of bath care was not documented for resident #001. [s. 6. (9) 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 the plan of care set out clear directions to staff and others related to lap belt, to ensure SDM participate fully in the development and implementation and that bath care is documented, 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 it complied with its policy to promote zero tolerance as per the LTCHA, 2007, S.O. 2007, c. 8, s.20(1), when alleged abuse of a resident was not immediately reported to the Director, as indicated under the LTCHA,

2007, S.O. 2007, c. 8, s. 20(2)(d).

This finding is related to log # 031379-15:

According to O.Reg.79/10, s.2.(1)
Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

The home's policy on Prevention of Abuse and Neglect of a Resident Policy Number 750.65, dated on February 2016, indicates under Duty to Report, that any alleged harm, abuse or neglect done to a resident is mandatory.

Under procedure it indicates:

1. Report immediately any suspicion or allegation of resident abuse to the Charge Nurse.

2. The Charge Nurse will immediately examine the resident. If the allegation is one of physical abuse, take pictures of the affected area and determine whether physician needs to be called.

3. Document results of the examination.

4. Immediately report the allegation to the Administrator and Manager of Resident.

5. Have the staff member reporting or making the allegation immediately write a report of what they saw and heard.

Resident #049 is identified as having several medical.

A review of the resident plan of care, indicates that the resident is totally depending on staff for his/her personal care and that the resident is transferring with the assistance of two staff members and the use of a lift. Resident #049 is also followed by the geriatric team for behaviours.

A review of the resident progress notes indicates that on a specific date in October, 2015, resident #049 was complaining of pain to a specific area of the body and was provided with some analgesics. An assessment was completed and there was no redness, no edema, no warmness to touch and that a close monitoring would be done.

On a specific date in October, 2015, resident #049 was observed with a bruise measuring 5 centimeters from unknown origin with pain to touch and nausea. Analgesic was provided and the home physician was contacted and requested to have mobile x ray in to verify resident #049 left forearm.

Two days later, resident #049 had x ray taken.

Two days after the x ray was taken, resident #049 was diagnosed with a fractured.

At approximately one hour later, it is documented that the resident #049's SDM was contacted and was informed of the x ray result. It further indicate in the resident health care records, that the SDM inquired why he/she had not been informed of the x-ray done on a specific day of October 2015 and requested to have the physician to contact the family back upon his next visit to the home.

It is documented in a late entry for a specific date in October 2015, that two family members were at the home site, including the SDM and inquired to RN #131 why they were not informed on that specific date in October 2015, when the pain and the bruising were observed on resident #049 and also about the requested x-ray by the physician. It is further documented that the family had voiced some concerns to RN #131 regarding the fracture and the potential of physical abuse. It is documented that RN #131 would report their voiced concern to her manager.

On June 07, 2016, in an interview with RN #131, she told inspector #592 that the home's expectations upon becoming aware of any alleged abuse is to report to their manager immediately and if after hours, to contact the on call supervisor. Upon asking RN #131 about the progress notes done on a specific date in November 2015 regarding resident #049 and the alleged physical abuse voiced by the family members, she confirmed she did not report the incident until the next day, verbally to her manager, therefore did not follow the home's abuse policy.

On June 07, 2016, in an interview with the Resident Care Manager (RCM) # 137, she told Inspector #592 that she was not made aware of any alleged physical abuse towards resident #049 and that in the case that she would have been informed, she would report it immediately to the Director and conduct an immediate investigation but was not made aware until now.

On June 07, 2016, in an interview with the home's administrator, she told Inspector #592 that upon any alleged harm, abuse or neglect done to a resident, the expectation is to have the Registered Nurse contact the Manager immediately by documenting on an incident report which will be flagged directly to their software system. She further told Inspector #592 that if the incident is reported after the operational hours of the home, the Registered Nurse will contact the on call supervisor immediately upon becoming aware of any alleged abuse and will complete an incident report. Then, a Critical Incident report will be done by the Manager, to report to the Director immediately upon becoming aware. Administrator told Inspector #592 that she was not made aware of any alleged abuse for resident #049 and if so, she would of report it directly to the Director. [s. 20. (1)]

2. The licensee has failed to ensure that the policy that promotes zero tolerance of abuse and neglect of the residents was complied with.

This finding is related to log # 006558-16

On a specific date in February 2016, a family member of resident # 040, informed Registered Nurse (RN) #131, that he/she reported to the family that there was alleged physical abuse,staff to resident. RN #131 left on an 18 days leave in February 2016 after being informed of the alleged abuse. Upon her returned, RN #131 reported the alleged physical abuse to the two Managers of Resident's Care (MRC). MRC #121 notified the Ministry of Health Care and Long Term Care's Director via Critical Incident System on a specific date in February 2016.

RN # 131 did not immediately report the allegation to the Administrator and Manager of Resident as per policy on Prevention of Abuse and Neglect of a Resident Policy Number 750.65, dated on February 2016 [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 the policy to promote zero tolerance is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle includes menus for regular, therapeutic and texture modified diets for both meals and snack.

On May 26, 2016, while conducting stage 1 interviews, Inspector #126 observed Dietary Aid (DA) #113 in the afternoon, going around passing beverages to residents. Inspector #126 observed that there was no texture modified beverages on the tray. DA #113 indicated that she had no time to get the modified texture beverages out. She indicated that she usually put them at the nursing station and it is the responsibility of the nursing staff to give those beverages. No texture modified diets were observed at the nursing station.

On May 30, 2016 around 1400 on the fifth floor, Inspector #126 spoke with DA #114 who was preparing the snacks and indicated that she prepares juices, water and wrapped cookies. When DA was asked about therapeutic snacks, she indicated that in the past, they used to have different types of food for therapeutic diet but now this is what they have. No nursing staff indicated that they pass the therapeutic diet in the afternoon and no staff was observed passing therapeutic snacks to residents.

On May 30, 2016 around 1430 on the fourth floor, Inspector #592 spoke with the DA #113 distributing the snacks and indicated that is the responsibility of the dietary Aid to pass the snacks in the afternoon and today she was going to offer cookies. When DA was asked about what was going to be offered for textured modified diet, she indicated that she could add apple sauce and that she was leaving the modified snacks at the nursing station but staff would say that they are not distributing them because residents are sleeping in the afternoon.

Upon a review of the home's menu, it was indicated for May 30, 2016 under PM collation, to offer blueberry cookies. No other food item was noted.

In an interview with the Food Service Manager(FSM), he told Inspector #592 that the home's menu is a four week cycle menu for meals and snacks and confirmed that each food item on the menu was modified as per the resident texture's needs as recommended by the dietitian. He further confirmed that the current menu is the menu approved by the dietitian since January 2016. The FSM told Inspector #592 that the main snack is the regular food texture offered to residents and for the therapeutic and texture modified diets, if the employee are unable to modify the texture of the main snack , they will provide another food item which was not written on the home menu cycle. He further told Inspector #592 that some of the food such as blueberry cookies, donuts, butter tart were food that the home were unable to modified with the recommended texture. [s. 71. (1) (b)]

2. The licensee failed to ensure that each resident is offered a snack in the afternoon and evening.

On May 30, 2016 around 14:30 on the fourth floor, Inspector #592 spoke with the DA #113 distributing the snacks and indicated that is the responsibility of the DA to pass the snacks in the afternoon and today she was going to offer cookies. When DA was asked about what was going to be offered for textured modified diet, she indicated that she could add apple sauce and that she was leaving the modified snacks at the nursing station but staff would say that they are not distributing them because residents are sleeping in the afternoon.

In an interview with the Food Service Manager(FSM), he told Inspector #592 that each food item on the menu was modified as per the resident texture's needs as recommended by the dietitian. The FSM told Inspector #592 that following the

discussion with the Inspector #592 and #126 the day before, it was confirmed by the dietary staff members that no afternoon snacks for therapeutic and textured modified diet were prepared on the snack cart because the nursing staff were not distributing it, due to lack of time therefore the dietary staff were no more preparing therapeutic and texture modified food due to waste of food. He further told Inspector #592 that he was not sure of how long this practice was going on but that the home will ensure that all the residents will receive a snack in the afternoon. [s. 71. (3)]

3. The licensee has failed to ensure that each resident is offered a minimum of a between-meal beverage in the morning.

On June 1, 2016, at 1010, Inspector # 126 was sitting at the nursing station on the 4th floor nursing station and observed a tray with jars of orange and apple juices, water and a can of thickener.

At 1055, resident # 030 came by the nursing station and asked for a glass of water. Registered Nurse(RN) # 117 gave a glass of water to resident # 030.

At 1115, Dietary Aid(DA) # 133 came by to take the cart away to bring it back to the kitchen. Inspector # 126, interviewed DA # 133 who indicated that the nursing staff was in charge of passing the beverages in the morning.

Interview held with RN # 117 who indicated that the beverages should have been pass by the Personal Support Worker. RN # 117 was unable to identified the PSW that was supposed to pass the morning beverages. Inspector # 126 informed RN # 117 that it was observed that the beverage tray was at the nursing station from 1010 to 1115 when it was taken away by the DA and that the morning beverage was not passed to residents except for resident # 030 who came at the nursing desk to ask for a glass of water.

Therefore no beverages was offered to the resident on the fourth floor unit. [s. 71. (3) (b)]

4. On June 01, 2016 at 0950, Inspector #592 observe the beverage cart in front of the elevators near the nurses desk with one jar of apple juice, one jar of orange juice and one jar of water in regular texture. Inspector #592 also observed one container of apple juice, orange juice and water in nectar texture.

Inspector #592 observed that between 0950 and 1110, the beverage cart was left untouched and that residents in the activity room and residents sitting beside the nursing

station were not offered any beverages.

At 1110, Inspector #592 observed the Dietary Aid (DA) removing the beverage cart from the unit.

At 1120, in an interview with the DA #113, she told Inspector #592 that she brought the beverage cart on the unit at 950 and brought it back to the kitchen at 1110. She further told Inspector #592 when ask what was the amount left in the jars, that the beverages containers were still full as if they were not given to the resident on the unit.

At 1123, in an interview with the Administrator, she confirmed that all residents should be offered a between meal beverage and that she would do a follow-up immediately with her managers.

On June 02, 2016, (0830), in an interview with the Resident Care Manager (RCM) # 121, she told Inspector #592 that after the follow-up with the staff members on June 01, 2016, it was confirmed that no staff had offered beverages to residents as there was no staff members assigned. She further told Inspector #592 that since the follow-up, the home as assigned a staff member to ensure that each resident will be offered a between meal beverages.

On June 02, 2016,(1415), upon reviewing the home documentation, it was noted that there was a form titled " Record d'alimentation et liquides" for all the residents. Upon reviewing the form for resident #016, #044, #45 and #046, documentation was observed as follows:

June 01, 2016,(1000), resident #016 was identified as having consumed 50 per cent of liquid.
June 01, 2016,(1000) resident #044 was identified as having consumed 75-100 per cent of liquid.
June 01, 2016 (1000), resident #045 was identified as having consumed 75-100 per cent of liquid.
June 01, 2016,(1000), resident #046 was identified as having consumed 50 per cent of liquid.

On June 03, 2016, in an interview with the RCM # 121, she told Inspector #592 that the expectation of the staff members was to document at each snacks and each meals, each resident's intake including solid and liquid on the "Record d'alimentation et liquid" form.

She showed to Inspector #592 the policy titled "Programme de gestion de l' hydratation" # 220.12 approved on January 2005 which indicates:

Under Procedures:

The PSW should document the daily intake for each resident on the " Programme de gestion de l'hydratation" .

The RCM # 121confirmed with Inspector #592 that the "Programme de gestion de l' hydratation" forms were documented for the residents above and that it was falsification of information. [s. 71. (3) (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 texture modified snacks are available and are offered to residents and that residents are offered a minimum of a between meal in the morning,, 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 labelled and are kept inaccessible to residents at all time.

On May 31st, 2016, at 900, Inspector #592 was on her way to the kitchen on the main floor and observed a room titled "salle d'entreposage" left open with a set of key left on the door lock. A postage signage was observed indicating "keep door close". The room was containing several cleaning products on shelves. Inspector #592 did not observed any staff around.

Inspector #592 observed:

One gallon of Oasis 146, Multi-Quat Liquid sanizer
One gallon of Ultra-San, Sanitizer
One gallon of Ultrakleen Plus Detergent
One gallon of Lemon-Eze, Bathroom Cleanser
One gallon of Grease Express High Temp Grill Cleaner and
One gallon of Oasis 115, extra strength floor cleaner concentrate

At 9:15, the Resident Care Manager(RCM) # 137 accompanied Inspector #592 to the "salle d"entreposage room" and observed that the door was still left open. She told Inspector #592 that the storage room contains cleaning and disinfecting products and that this area was considered a residential area, therefore, accessible to all residents. She further told Inspector #592 that the door should have been close and lock. The RCM # 137 with the presence of Inspector #592, was confirmed by one of the staff member that she forgot to close the door when she went earlier in the room.

As per the Canadian center for occupational Health and Safety Canada, category 1 is defined as the greatest level of hazards. Safety product Material Safety Data Sheet were obtained by the home and the products listed above are defined as category 1 and were accessible to the residents in the home. [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 at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

On May 25, 2016, inspector #592 observed that resident #16 was wearing a lap belt.

On June 3, 2016, inspector #211 and RN #100 observed resident #16 sitting in the tilted wheelchair and restrained with a seat belt.

Review of resident #16's current plan of care did not indicate that resident requires a sit belt while sitting in the wheelchair.

Interview with PSW #128 revealed she applied the resident's seat belt since he/she was agitated this morning.

Interview with RN #100 and the Resident Care Manager # 121 confirmed that the resident's seat belt should not have been applied since the restraint was not ordered or approved by the physician. [s. 110. (2) 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 that where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or in a medication cart that is secure and locked.

On May 26, 2016, during stage one Resident Quality Inspection, Inspector # 592 observed a small bottle of prescribed topical cream in a shared bathroom for resident # 014. Inspector # 592 interviewed resident # 014 who indicated that the cream is applied if needed.

On June 2, 2016, Inspector # 126 observed the small bottle of prescribed topical cream in the open cupboard in the shared bathroom. Inspector # 126 interviewed Registered Practical Nurse(RPN) # 116 who indicated that all resident's cream shall be kept in the medication cart after administration. [s. 129. (1) (a)]

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 are stored in an area or in a medication cart that is secure and locked., to be implemented voluntarily.

WN #7: 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, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Centre D'Accueil Champlain is a five level home with a total of 10 units.

On May 24 and 30th , 2016, Inspector #592 observed that the soiled utility room on the fifth floor on the east unit was close but not locked. The door is equipped with a door access control card system. The soiled utility room was containing soiled continent products in garbage bags, soiled linens in hampers and found to be accessible to residents with no staff supervision.

In interview with Housekeeping(HKP) staff # 105, he told Inspector #592 that the staff has to use their access card to open the door as it is to be kept close and lock at all times. HKP #105 confirm with Inspector #592 that the door was able to close but unable to engage the lock system.

On May 24 and 30th, 2016, Inspector #592 observed that the soiled utility room on the fourth floor on the east unit was close but not locked. The door is equipped with a door access control card system. The soiled utility room was containing garbage bags and found to be accessible to residents with no staff supervision. Inspector #592 also observed the clean linen room on the same floor, on the west unit, close and door handle lock but by pushing the door handle, the door opened.

In an interview with PSW #104, he told Inspector #592 that staff needs to use their access card to open the soiled utility room and showed to Inspector #592 how the swiping card worked. PSW #104 was able to open the door but told Inspector #592 that the door was unable to latch properly causing the door to not lock after being close and that he was not aware of it. PSW #104 also open the clean linen door on the west unit by pushing on the door handle.

In an interview with the Administrator, she told Inspector #592 that the soiled utility rooms were considered non-residential areas, therefore were kept close and lock at all times. She further told Inspector #592 that the soiled utility rooms were equipped with a door access control card system and the clean linen room were equipped with a regular lock. She told Inspector #592 that she was not aware of the disrepair and that the maintenance department would fix the doors shortly. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written complaint concerning the care of a resident was immediately forwarded to the Director.

In reviewing resident #017's health care record, it was noted in the record that a complaint letter dated a specific date in March 2016, was sent to the attention of the Resident Care Manager (RCM) # 137.

The written complaint was about resident's #017 family members who had return with the resident from a follow-up appointment. The complaints indicate that the surgeon was extremely disappointed at the level of care resident #017's been receiving for a specific area of the body and because the care was not provided as expected, resident #017 may require more treatment.

In an interview with the Administrator, she told Inspector #592 that she is the person in charge of reviewing the written complaint before they are being sent to the director. After reading the complaint the administrator told Inspector #592 that this complaint should have been immediately forwarded to the Director.

In an interview with the RCM # 137, she told Inspector #592 that she did a verbal follow-up with the family member within 10 days of receiving the written complaint and that following the internal investigation, there was no evidence to support the lack of care provided to resident #017. She further told Inspector #592 that she did not forward the written complaint to the Director. [s. 22. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care include oral hygiene.

Discussion held with resident # 028, on May 31st, 2016, who indicated that he/she requires total assistance with her mouth care. Resident # 028, indicated that the sitter assist him/her with the mouth care twice a day on a daily basis from Monday to Friday.

Resident # 028's plan of care was reviewed for oral hygiene and it was noted that the plan of care dated April 09, 2016, does not include resident's dental/oral status including oral hygiene.

On June 1, 2016, Inspector # 126 interviewed RAI Coordinator regarding oral hygiene/mouth care documentation in plan of care. She indicated that oral hygiene was to be documented under Activity of Daily Living(ADL). In reviewing resident # 028's plan of care she did not find any documentation related to the resident's oral hygiene/mouth care. The RAI Coordinator, indicated that she reviewed the plan of care of several residents and that oral hygiene/mouth care was not documented and indicated that it will not trigger in the plan of care unless the staff document that resident was observed with food debris in the mouth and that can be easily removed.

On June 1, 2016, Inspector # 126 interviewed Registered Nurse (RN) # 108 regarding the documentation in the plan of care related to oral hygiene/mouth care. RN #108, indicated that oral hygiene/mouth care does not trigger automatically in the plan of care and need to be added to the plan of care. [s. 26. (3) 12.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On three specified day in May 2016, Resident #019 was observed by Inspector #592 with long facial hair covering the chin.

The current plan of care for Resident #004 indicated that the resident required total assistance with personal hygiene.

On May 27, 2016, in an interview with PSW #101, she told Inspector #592 that the shaving of male and female residents was done on a daily basis while providing personal hygiene to the resident. She further told Inspector #592 that resident #019 was depending on staff for all the personal care and confirm the resident had a long facial hair which was not trimmed for several days due to the length of the hair.

On May 27, 2016, in an interview with PSW #102, assigned to the resident, she told Inspector #592, that resident #019 was totally depending on staff for personal hygiene (including shaving). Confirm with Inspector #592 that the home's expectation was to provide shaving to residents on a daily basis and that resident #019 had long facial hairs and that she will trim them later this afternoon.

On May 27, 2016, in an interview with the DOC, she told the Inspector that all the residents are being provided individualized personal care, including shaving for male and female resident and that she was expecting each resident to be shaved on a daily basis. [s. 32.]

2. Inspector #550 observed resident #001 on May 26 and 31, 2016 and observed the resident to have long facial hair on her chin and upper lip and fingernails to be dirty with brown matter under them. PSWs S#123 and S#124 indicated to the inspector the

resident does not resist to care, the facial hair should be removed during the morning care. They both indicated the resident eats with his/her hands and this is the reason the nails are dirty. He/she does not want to have them cut but it should be cleaned by staff when they are dirty.

During an interview, the Resident Care Manager S#121 indicated to the Inspector that any resident with facial hair should have them removed during morning care and that if the nails are dirty they should be cleaned when required.

As evidenced above, resident #001 did not receive individualized personal care for shaving and the cleaning of nails on a daily basis. [s. 32.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council minutes was done by Inspector #592. Residents expresses concerns at several meetings, where there was no evidence of written responses from the licensee.

March 16, 2016 meeting:

Concerns identified in housekeeping:
Soiled linen, not enough room in resident's bedroom, resident are requesting a specific area as mentioned in the other meetings.

Nursing:
Nurses enters in the dining room with the medications

Nutrition:
Residents would like some cream on the table in the morning
Residents would like some water on the table for lunch and dinner on fourth floor
During outbreak, meals and beverage cold, no milk and resident did not like the bibs that were covering the meal trays
A glass was found on the floor and it was given to a resident for use instead of being washed

No documented responses was found

April 11, 2016 meeting:

Nursing:
Resident complained about the medication pass being too long.

No documented responses was found

May 09, 2016 meeting:

Nutrition:
Sugar bowls dirty on tables
Staff apron's not wear correctly
Residents would like butter and margarine on the tables

No documented responses was found

During an interview with the Activity Director the Assistant to the Residents' Council , he told Inspector #592 that the licensee is responding within 10 days to any complaints brought forward at the resident council meeting by sending a template to the concerned department/manager. He further told Inspector #592 that he was unsure what was considered a complaint and thought that only the complaints had to be responded within 10 days, therefore was not forwarding on the home's templates for the managers to follow, the additional concerns or recommendation brought forward by the Resident's council. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt as follows;

(2) The licensee shall ensure that a documented record is kept in the home that includes,

(a) the nature of each verbal or written complaint;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

On a specific date in March 2016, a written complaint to the attention of the Resident Care Manage(RCM) # 137 was sent to the home.
The written complaint was about resident's #017 family members who had returned with the resident from a follow-up appointment. The complaints indicated that the surgeon was extremely disappointed at the level of care resident #017's was receiving for a specific area of the body and because the care was not provided as expected, resident #017 may require more treatment.

In an interview with the Administrator, she told Inspector #592 that the home has to respond and do a follow-up within 10 days regarding any written or verbal complaints. She further told Inspector #592 that a complaint form would be completed as well with the respond to the complainant, the outcome and resolution regarding the care of the resident.

In an interview with the RCM # 137, she told Inspector #592 that she did a verbal follow-up with the family member within 10 days of receiving the written complaint and that following the internal investigation, there was no evidence to support the lack of care provided to resident #017. She further told Inspector #592 that she was unable to provide any of the documentation regarding the complaint above as she did the follow-up with the family verbally, therefore was unable to provide the type of action taken, the final resolution and any response to the complainant. [s. 101. (2)]

Issued on this 16th day of June, 2016

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

Original report signed by the inspector.