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 soins 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
Aug 17, 2016	2016_284545_0021	016924-16, 019943-16, 020814-16	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

ANGELE ALBERT-RITCHIE (545)

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): July 21, 22, 25 and 26, 2016

Three complaint inspections were conducted during this inspection:
Log #: 016924-16 related to a complaint regarding transferring techniques, care provision, housekeeping and maintenance issues
Log #: 019943-16 related to a complaint regarding repositioning techniques and resident comfort
Log #: 020814-16 related to a complaint regarding an outbreak in the home

Non-compliance was issued for Log # 016924-16 and Log # 019943-16; please refer to Critical Incident System Inspection Report # 2016_284545_0020.

The following Critical Incidents were also inspected during this Complaint Inspection:
-Log # 016933-16
-Log # 021541-16
-Log # 015162-16

During the course of the inspection, the inspector(s) spoke with the Program Manager of Resident Care/Acting Administrator, Program Manager of Personal Care, RAI Coordinator, Environmental Services Manager, Environmental Services Supervisor, Maintenance Staff, Laundry Aide, Dietary Aides, Activity Aides, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW) and residents.

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures related to Complaints, Restraints & Maintenance, staff work routines and schedules, observed resident rooms, observed resident common areas, observed a Medication Cart, observed a meal service, and observed the delivery of resident care and services, including resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control
Personal Support Services
Reporting and Complaints

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

- **2 WN(s)**
- **1 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #004, restrained by a physical device as described in paragraph 3 of subsection 30 (1), was included in the resident's plan of care.

Resident #004 was admitted to the home with several medical conditions. According to the most recent RAI-MDS assessment, it was documented that resident #004 had upper body limitation with partial loss of movement and no physical restraints or devices were in use.

During a dining observation on July 22, 2016 at 0815 hours, Inspector #545 observed resident #004 sitting in a slightly reclined wheelchair with a fastened front seat belt and a table top in place, and seated alone at a dining room table, eating breakfast using his/her left hand. At 0842, resident #004 stated "Help, Help, Help", PSW #118 who was providing assistance to another resident, turned around and asked the resident how she could help. The resident asked for water, then told the PSW that his/her belt was fastened too tight. The Inspector observed PSW #118 verifying the seatbelt and unfastened it.

On July 22, 2016 at 1400 hours, the Inspector observed resident #004 in a reclined wheelchair watching television. The seatbelt was not fastened.

During an interview with PSW #106 on July 22, 2016, she indicated that she had applied the seatbelt because in her view the resident could become agitated during meals and she thought the seatbelt should be fastened as it was available and hanging on both sides of the wheelchair. She confirmed that the resident would not be able to unfasten the seatbelt due to limitation and partial loss of movement to a specific limb. The PSW later indicated to the Inspector that another staff member had informed her after breakfast that the seatbelt should not have been applied.

At 0933 hours on July 22, 2016 RPN #105 walked by resident #004 and noticed that the resident's seatbelt was unfastened. As she was about to fasten it, PSW #119 indicated to the RPN that the resident should not have a seatbelt. The RPN turned to the Inspector and indicated that she was not regular on the unit, therefore was not aware of who should or should not have a restraint applied.

In a review of resident #004's plan of care, a restraint by physical device was not found. (Log # 016924-16) [s. 31. (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 ensure that residents with a physical device, as described in paragraph 3 of subsection 30 (1), are included in the residents' plan of care, to be implemented voluntarily.

WN #2: 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, such as the walls in resident #004's bedroom were maintained in a good state of repair.

Resident #004's family member reported that the walls in the resident's room had been heavily damaged for some time and wondered if staff were hitting the wall with the mechanical lift during transfers of the resident from the bed to the wheelchair and vice-versa.

Inspector #545 observed resident #004's bedroom and noted the following walls in a bad state of repair:
- the walls on both sides of the door frame of resident's bathroom, from floor to approximately three feet up had deep long scratches exposing dry walls
- on one side, under a hook, the wall was damaged, exposing dry wall which was crumbling and pieces had fallen off

- on the wall by the closet near the entrance of the bedroom, again from the floor to approximately three feet up, deep long scratches appeared exposing dry wall

During interviews with PSW #106 and Laundry Aide #129, they indicated they were expected to report any damaged walls, furnishings or equipment to the Call Centre at the City of Ottawa by dialing extension 29999 or by reporting it to their own supervisor.

RN #109 indicated that it was the responsibility of all staff to report any damaged furnishings, including walls to the Maintenance Department by dialing extension 29999. She indicated that often staff reported disrepair to the nurses instead of reporting it by dialing extension 29999 at the Call Centre, but staff were regularly reminded at team meetings that it was their responsibility. She indicated to the Inspector that she had not been made aware of the state of disrepair of resident #004's bedroom walls, added that the damaged walls might have been caused by either the mechanical lift or wheelchair. After verifying resident #004's bedroom, she agreed that the walls were heavily damaged and were in need of repair.

Environment Services Manager (ESM) #126, Environmental Services Supervisor (ESS) #128, and Maintenance Staff #127 indicated that they had not been made aware of the state of disrepair of the walls in resident #004's bedroom. They all indicated that staff were expected to report to the Call Centre by dialing extension 29999 any furnishings, walls or equipment that required repair. In presence of ESS #128, he agreed that the walls were heavily damaged and were requiring repair, he added that a service request would be made today and repair would be done within a few days. (Log # 016924-16) [s. 15. (2) (c)]

Issued on this 19th day of August, 2016

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

Original report signed by the inspector.