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
Mar 8, 2017	2017_620126_0002	035031-16	Follow up

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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 Follow up inspection.

This inspection was conducted on the following date(s): February 16, 17, 18, 22 and 23, 2017

During this inspection four Critical Incidents(CI) related to allegations physical abuse and one CI related to an allegation of sexual abuse were inspected

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Manager (RCM) for registered nursing staff, the RCM for non registered nursing staff, the Geriatric Psychiatry Outreach nurse, the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

Residents health care records were reviewed and residents were observed. Inspector # 126 reviewed documentation related to the home's investigations into the above critical incidents and policies related to the home's prevention of abuse programs.

Please note that LTCHA, 2007, S. O. 2007, c.8, s.3 should not have been complied at this time for this inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	WN	2016_219211_0021	126
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_219211_0021	126
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2015_381592_0021	126

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. 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 failed to ensure that there is a written policy that promotes zero tolerance

of abuse and neglect of the resident and that it is complied with.

The home's Abuse Policy, Policy and Procedures: 750.65 last revised date of September 2016 requires nursing staff under the section:

Procedure:
1)"Report immediately any suspicion or allegation of resident abuse to the Charge Nurse. Definition of abuse as per LTCHA and appendix A."

O. Reg. 79/10, s.2 (2) (a) define physical abuse as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain

A Critical Incident (CI) was submitted to Ministry Of Health and Long Term Care (MOHLTC) on a specific day of July 2016 for an allegation of physical abuse, staff to resident #008. The allegation of abuse occurred two days before it was submitted to MOHLTC.

On a specific day of July, 2016, Registered Practical Nurse(RPN) #100 documented in the progress notes that resident #008 reported to her, that a Personal Support Worker (PSW) (#103) told resident #008 to be quiet because the resident was yelling loudly during the night. Resident #008 indicated that PSW #103, squeezed her/his hand while he/she was holding on to the bed rail. At that time, RPN #100 documented in the progress notes that resident #008 nails was broken on the left small finger.

Two days later after the initial reporting of the incident to RPN #100, in July 2016, Registered Nurse (RN) #101 documented in the progress notes that resident #008 had two bruises on top of the left hand, one bruise was the size of a looney and the other bruise was the size of a 5 cents.

On February 23, 2017, during an interview, RPN #100, indicated to Inspector #126, that she does not recall having notified anyone about the allegation of physical abuse reported by resident #008 on that specific day of July, 2016.

On February 23, 2017, during an interview, RN #101, indicated to Inspector #126, that she does not recall the incident of July 2016. RN #101 indicated that she became aware of the incident of July 2016, when the past RCM of registered nursing staff came to the unit on two days after the incident and ask questioned about the allegation of abuse

reported by resident. #008.

On February 22, 2017, during an interview, the actual RCM of registered nursing staff, indicated to Inspector #126, that as soon as the previous RCM became aware of the incident, she immediately notify the Director and the investigation was initiated that same day.

On February 22, 2017, during an interview with the Administrator, she indicated to Inspector #126, that as soon as the Management Team became aware of the allegation of abuse, an investigation was initiated and completed.

RPN #100 did not immediately report the allegation of physical abuse to the Charge Nurse as per the home's Abuse Policy. [s. 20. (1)]

Issued on this 8th day of March, 2017

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

Original report signed by the inspector.