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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Jun 29, Jul 17, 18, 2017	2017_618211_0009	005563-17	Complaint

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

JOELLE TAILLEFER (211)

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): May 26, 29, 30, 31, 2017 and June 12, 2017.

The complaint inspection Log #005563-17 was conducted related to resident’s care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Resident Care, Hospitality Manager, Resident Care Finance Officer, Program Manager and Recreation and Leisure, Social Services, Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Laundry Attendant, hairdresser, resident and a family member.

During the course of the inspection, the inspector(s) reviewed residents’ health care records, relevant licensee policies and procedures, staff work routines, observed resident rooms, the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

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

2 WN(s)
2 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #001 was admitted to the home on an identified date and diagnosed with cognitive impairment and other health issues.

Review of the resident's written plan of care on an identified date, indicated that the resident has edema and redness to two identified body areas since an identified date due to a medical diagnosis.

The health care progress notes written by the physician were reviewed by inspector #211 and indicated the following:
On an identified date, the resident sustained an infection of an identified body area and an antibiotic medication was prescribed.
Four days later, the resident's identified body area had edema with a small area of altered skin integrity and to continue the prescribed antibiotic.
Ten days later, the area is still red and to continue the antibiotic.

The health care nursing progress notes reviewed by Inspector #211 indicated the following:
On an identified date, resident #001 was complaining of pain during mobility and there was redness of the identified body area and the area was warm to touch.
Four days later, the resident had edema and redness to two identified body areas. The resident was diagnosed with an identified infection and presently receiving antibiotics.
Three days later, there was a small amount of drainage from the resident's identified body area and the area was cleaned with normal saline and an identified dressing was applied.
At approximately three weeks later, the resident was administered an antibiotic for the identified infection.
At approximately eight weeks later, the resident has no wound.

During an interview with the RN #104 on May 30, 2017, she indicated that the Skin Assessment Tool form is not used for this specific altered skin integrity infection.

During an interview with the Program Manager of Resident Care on May 31, 2017, stated since the physician progress notes on an identified date, indicated that the resident's identified body area had altered skin integrity, the home's Skin Assessment Tool form should have been started. On the same day, the Program Manager of Resident Care mentioned that the Skin Assessment Tool form should have been completed to monitor weekly the resident's wound area.

The licensee has failed to ensure that resident #001 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds to the identified body area on an identified date, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that resident #001 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration been implemented.

Review of the resident's written plan of care on an identified date, by inspector #211, indicated that the resident had edema and redness to two identified body areas since an identified date due to a medical diagnosis.

During an interview with the Registered Dietician (RD) on May 31, 2017, the RD indicated to inspector #211 that she did not receive a referral related to the resident’s identified altered skin integrity.

During an interview with the Program Manager of Resident Care on May 31, 2017, indicated that a referral should have been made to the RD when the resident’s exhibited altered skin integrity. [s. 50. (2) (b) (iii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
-receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
-is assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the resident’s written plan of care on an identified date, indicated that the resident had edema and redness to two body areas since an identified date due to a

specific medical diagnosis.

The health care progress notes' written by the physician indicated the following:
On an identified date, the resident sustained an identified infection of an identified body area and an antibiotic medication was prescribed.
Four days later, the resident's identified body area had edema with a small area of an identified altered skin integrity and to continue the prescribed antibiotic.
Ten days later, the area is still red and to continue the antibiotic.

Inspector #211 reviewed the physician's order on an identified date that indicated to administer an identified medicated cream to both identified body areas DIE.

During an interview with RN #104 on May 31, 2017, she indicated that the abbreviation DIE signify once a day.

Inspector #211 reviewed the resident's Medication Administration Records (MAR) for an identified month. Inspector #211 observed that the MAR was transcribed improperly and the resident received the above medication twice a day as opposed to once a day as ordered by the physician on five identified days.

During an interview with RN #104 on May 31, 2017, she indicated she transcribed the physician's order on the identified date to the MAR identified month wrongly by writing to be given on days and evenings. During the interview, she also indicated that the prescribed medication was given twice a day on five identified days when it should have been given once a day.

During an interview with the Program Manager of Resident Care on May 31, 2017, she indicated that the prescribed medication was not administered in accordance with the directions for use specified by the prescriber.

The licensee has failed to ensure that the prescribe medication was administered to resident #001's on both identified body areas in accordance with the directions for use specified by the prescriber on five identified days. [s. 131. (2)]

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 administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 18th day of July, 2017

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

Original report signed by the inspector.