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

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 # / No de registre	Type of Inspection / Genre d'inspection
Feb 2, 2018	2017_621547_0020	022665-17, 024185-17, 025492-17, 025999-17, 026003-17	Critical Incident System

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

LISA KLUKE (547), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 6,7,8,11,12,13,18,19,20,21,2017

The following critical incidents submitted by the Licensee were conducted concurrently during this inspection:
Log #022665-17 regarding an alleged resident to resident inappropriate touching of a sexual nature,
Log #024185-17 regarding a resident fall with injury,
Log #025492-17 regarding an alleged resident to resident physical altercation, and
Logs #025999-17 and #026003-17 regarding alleged improper care of resident's with injuries.

Follow-up to order inspection #2017_261547_0019 was conducted concurrently during this inspection. A finding of non-compliance related to a log #025999-17 is issued under the follow-up report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Care (PMRC) and the Program Manager of Personal Care (PMPC), an Office Manager, a ward clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping attendants, Residents and Family Members.

In addition the inspectors reviewed resident health care records, documents related to education including staff sign in sheets for : Prevention of Abuse and Neglect and reporting requirements, Review of the course completion lists of staff in the home for the Surge learning on Abuse Policy #750:65 (2017) in both English and French. Reviewed the most current policies and procedures related to Abuse and Neglect and Incident Reporting: Residents. The inspection team reviewed Complaint forms and investigations documents for the identified critical incidents. The inspectors observed the delivery of resident care and services and staff to resident as well as resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that where an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, the licensee did not contact the hospital within three calendar days, and did not inform the Director of the incident within three business days after the occurrence of the incident.

The home submitted a Critical Incident Report (CIR) to the Director under the LTCHA on a specified date for an incident that occurred 13 days earlier involving resident #006.(Log # 024185-17)

Inspector #592 reviewed resident #006's health care records, that indicated the resident was admitted to the home on a specified date with several medical diagnoses. The health care records indicated that resident #006 ambulated independently on the unit and required supervision with limited assistance of staff for personal care. Resident #006's progress notes documented that the resident had fallen on two occasions on a specified date within a short period of time, while ambulating on the unit. Within 24 hours, the resident was found with a decrease in muscular strength and discomfort identified to a specified limb. The progress notes further indicated that the family had been contacted and refused to send the resident to the hospital. The family had instructed the home to keep the resident comfortable until the mobile x ray services would come to assess the resident on a specified date, five days after the falls occurred. Resident #006 was sent to the hospital after the x-ray was completed with the family's approval. The progress note documented on the day the resident was transferred to the hospital, indicated that the hospital had contacted the home later that day, to inform them that resident #006 had a specified fracture that required surgery that was booked for the next day. Resident #006 returned to the home fourteen days after the falls occurred.

On December 18, 2017 the Program Manager of Personal Care (PMPC) indicated to Inspector #592 that she was made aware of the physical status and the significant change in the resident's health condition of resident #006, the day after the resident was admitted to hospital and created a CIR on that day. The PMPC indicated that she was unable to explain why the CIR was not submitted to the Director on that day. The home informed the Director on a specified date, eight business days after resident #006 was sent to the hospital. [s. 107. (3.1)]

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 an incident occurred that caused an injury to a resident for which the resident was taken to a hospital, the licensee is to contact the hospital within three calendar days, and to inform the Director of the incident within three business days after the occurrence of the incident, 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 of abuse as per the LTCHA, 2007, S.O. 2007, c. 8, s.20(1), when the 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).

According to O.Reg.79/10, s.2.(1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director regarding an allegation of sexual abuse which occurred earlier that same date, involving resident #001 and resident #002. (Log # 022665-17)

Inspector #592 reviewed resident #001's health care records:

The progress notes indicated that on this specified date at a specified time, resident #001 was found in resident #002's bedroom. Resident #001 was observed sitting on resident #002's bed, holding firmly one of the resident's hands while undressing resident #002 with the other hand. The notes further indicated that resident #002's clothes were completely removed and the resident's continence product was half ripped off. The notes further indicated that resident #001 was stopped immediately by two PSW's and one RN and was removed from resident #002's bedroom. The notes further described that immediately after the incident resident #001 inappropriately touched the RN when attempting to provide resident #001 with medications. One to one monitoring was provided to resident #001 immediately after this incident.

In a review of resident #001's health care records, it was indicated that resident #001 was admitted on a specified date with several medical diagnoses. Resident #001 was also identified with several behaviours such as wandering on the unit, being resistive to care and being physically aggressive with staff members. The health care records also indicated that at the time of the incident, resident #001 was ambulating independently and was not identified as having any sexual behaviours. Resident #001 was assessed as being unable to make any decisions due to poor cognitive functions at the time of the incident.

Inspector #592 reviewed resident #002's health care records history that indicated resident #002 was admitted on a specified date with several medical diagnoses including a speech impediment and a specified cognitive impairment with severely impaired decision making ability. The health care records indicated that resident #002 was dependent on staff for personal care, including transfers and bed mobility.

On December 12, 2017, PSW #115 indicated to Inspector #592 that she was one of the staff members who discovered this incident, and indicated that at around a specified time, she was notified by one of the residents on the floor that resident #001 was observed in resident #002's bedroom. PSW #115 indicated that she immediately went to resident #002's room and observed resident #001 sitting on resident #002's bed, holding one of the resident's hands firmly. PSW #115 observed that resident #001 had removed resident's #002's top exposing the resident and that the resident's continence product was half ripped off. PSW #115 indicated that resident #002 is dependent on staff members for care and that repositioning the resident is usually difficult due to the resident's joint stiffness and resistance to personal care. PSW #115 indicated that resident #002 was not able to mobilize in bed independently due to physical limitations and that prior to this incident, resident #002 had the continence product changed and the

resident was repositioned 30 minutes prior to this incident. PSW #115 indicated that resident #002 was not able to make decisions due to an advance cognitive impairment and was unable to express himself/herself verbally due to the resident's speech impediment, however PSW #115 observed resident #002 struggling and holding his/her clothes while resident #001 was removing his/her top. PSW #115 further indicated that the PSW yelled for assistance and reported this incident immediately to the RN in charge due to the severity of the situation.

RN #105 indicated to Inspector #592 that she was the RN responding to the incident on this specified date as she was covering resident #001 and resident #002's unit. RN #105 indicated that immediately after being notified of the incident by PSW #115, she went to resident #002's room and removed resident #001 from the room with the assistance of two PSWs. She indicated that she placed resident #001 on one to one supervision to ensure resident #001 was not in contact with any other residents, as resident #001 was still exhibiting sexual behaviours as the resident touched RN #105 inappropriately while she was trying to calm the resident down. RN #105 indicated that due to the severity of the sexual observations she contacted her co-worker RN #106, assigned to another unit for guidance as they were the two RN's working in the building at the time of the incident. RN #105 indicated that after speaking with RN #106, she was not provided with any instructions or guidance regarding the incident, and decided to send an email at the end of her shift to her manager. RN #105 indicated that usually she would have contacted the manager on call in the home, as per the home policy however she did not.

RN #106 indicated to Inspector #592 that she recalled talking to RN #105 on the shift of the incident and that at first she was unsure if the sexual gestures were towards RN #105 or between the two residents. She further indicated that she was informed about resident #001 sexual behaviours towards resident #002 at that time, but did not ask for any further clarification at that time and did not give any specific instructions to RN #105.

The documented incident on this specified date, can be determined as non-consensual sexual behaviour as resident #002 was unable to provide any consent due to advance cognitive impairment.

The home's Abuse policy #750.65 last revised in June 2017 in effect at the time of the incident, indicated that abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to the Charge Nurse/ respective supervisor. The Policy further indicated in the procedure, that the Charge Nurse will immediately report the allegation to the Administrator and Manager of

Resident Care or designated replacement.

The PMRC indicated to Inspector #592 that there was sufficient grounds to suspect that sexual abuse had occurred or might have occurred due to the non-consensual behaviour of a sexual nature by resident #001 towards resident #002. The PMRC further indicated that she was made aware of the incident when she read her email three hours later that same date and that the RN in charge on the that specified shift should have taken immediate action such as contacting the Manager on call as per the home’s policy in order to receive guidance. [s. 20. (1)]

2. 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, or the use of physical force by a resident that causes physical injury to another resident.

On a specified date, a Critical Incident Report (CIR) was submitted to the Director regarding an allegation of improper/incompetent treatment of a resident which occurred eight days earlier involving resident #005. (Log#025999-17)

The Program Manager of Personal Care (PMPC) indicated to Inspector #547 that the home was made aware of this concern from the resident's family of alleged staff to resident physical abuse that caused injury to resident #005's on a specified date. The resident's family indicated to Registered Nurse (RN)#101, as the charge RN on the resident's unit, that they noticed resident #005's specified limb was swollen with altered skin integrity. The resident's family further indicated to RN #101 that the resident had reported to them that someone had injured the resident's limb. PMPC indicated that RN #101 did not report this immediately to the Manager on call as required in the home's Abuse policy and procedure as required. The PMPC indicated that she was made aware of this incident the next day, when the resident's family met with her in her office reporting this concern for alleged staff to resident abuse causing resident #005's injury to a specified limb.

On December 20, 2017 RN #101 indicated to Inspector #547 that she did not identify this concern from the family at that time as being abuse, as the family expressed a suspicion of abuse as being the cause for resident #005's injury. RN #101 indicated that she did not report this concern to the Manager on call as she did not actually witness any abuse. RN #101 indicated that she left a voice mail with the Administrator on the specified date the family brought this to her attention, as she thought the Administrator would want to know about the family's concern. RN #101 further indicated that she was aware that the

Administrator was not working that day. RN #101 further indicated that she did go and do a head to toe assessment of resident #005 and noted that the resident's limb was injured as identified by the resident's family. She did not interview the resident as she indicated the resident had cognitive impairment.

The home’s abuse policy #750.65 last revised June 2017, indicated that abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to the Charge Nurse/ respective supervisor. This policy indicated in the procedure that the charge nurse will immediately report the allegation of abuse to the Administrator and Manager of Resident Care or designated replacement.

On December 19, 2017 the PMPC indicated to Inspector #547 that RN #101 was the charge RN in the building at the time this alleged abuse was reported to her. RN #101 was required to call the Manager on Call as the designated replacement to the Administrator or Manager of Resident Care. The PMPC further indicated that registered nursing staff are not supposed to leave a voice mail for Managers or the Administrator regarding abuse. As such, RN #101 was made aware of the alleged suspected physical abuse of resident #005 on a specified date and did not report this immediately to the Manager on call as required by the home's policy. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Resident #005 was admitted to the home on a specified date with several medical diagnoses.

On a specified date, the home submitted a critical incident report to the Director of the Ministry of Health and Long term care regarding an alleged improper/incompetent treatment of resident #005 that resulted in an injury to a specified limb.(Log #025999-17)

This alleged suspected improper/incompetent care of resident #005 was reported to the charge RN #101 on the floor on a specified date and this allegation was not reported immediately to the Director as required. This alleged suspected staff to resident abuse was then reported in a formal complaint to the PMPC the next day. The PMPC indicated that she immediately began her investigation however she did not report this critical incident to the Director until nine days after the incident was reported to the Licensee. [s. 24. (1)]

2. Resident #004 was admitted to the home on a specified date with several medical diagnoses.

On a specified date, the home submitted a critical incident report to the Director of the Ministry of Health and Long term care regarding an alleged improper/incompetent treatment of resident #004 that resulted in a specified injury to the resident. (Log #026003-17)

The Program Manager of Resident Care (PMRC) in the home indicated to Inspector #547 during an interview regarding this critical incident that on a specified date, the resident's Substitute Decision Maker (SDM) reported to her, concerns of alleged suspected physical abuse towards resident #004 related to the resident injuries. PMRC indicated that she immediately began her investigation, and called the police to make this report however she did not report this critical incident until a specified date that was over 24 hours from the time the Licensee became aware of this allegation of suspected physical abuse of resident #004 that resulted in harm to the resident. [s. 24. (1)]

Issued on this 2nd day of February, 2018

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

Original report signed by the inspector.