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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 19, 2018	2018_621547_0002	025660-17, 001323-18, 002725-18	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)

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): February 5, 6, 7, 8, 12, 13, 2018

The following Critical Incident Reports were reviewed:

log #025660-17 related to a choking incident of resident #002,
log #002725-18 related to an incident that caused an injury to resident #002, and
log #001323-18 related to improper/incompetent treatment of a resident that resulted in a risk to resident #001.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Managers for: Resident Care (PMRC), Personal Care (PMPC), and Activities (PMA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the home's Registered Dietitian (RD), an Activity Coordinator, residents and families.

In addition, over the course of the inspection, the inspector reviewed resident health care records, staff work routines, activity kardex's, observed resident rooms and mobility and transfer equipment, resident common areas, documents related to the home's investigations into the above listed critical incidents and reviewed several of the Licensee's policy and procedures. The inspector observed the delivery of resident care and services and staff to resident and resident to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care related to dressing and personal care and hygiene approaches were provided to resident #001 on an identified date as specified in the resident's plan.

On a specified date, resident #001's family provided the home a video clip of improper personal care provision of resident #001 by two nursing staff members on an earlier specified date and time. Inspector #547 reviewed this video clip that was provided by the Program Manager for Personal Care, who indicated that after review of this video clip, the resident's care was not provided as per the plan of care. The video clip demonstrated the two nursing staff members turning resident #001 from side to side in bed. RPN #114 was observed standing to the resident's left side, and PSW #113 was observed standing to the resident's right side. Resident #001 was observed naked, as they completed washing the resident, they applied a continence brief, and no communication with the resident was observed. The resident was observed to be trying to grab at the nursing staff and that the nursing staff simply removed the resident's grasp, and continued to provide care to the resident, without saying anything to reassure the resident or gently holding the resident's hands. This video then demonstrated the same nursing staff transfer the resident to a specified chair, and no communication was observed to reassure the resident. Once the resident was in the specified chair, the nursing staff began to dress the resident by applying a shirt, and no communication was observed by both staff members. RPN #114 was observed pulling the resident's right wrist in an upward motion, to straighten the resident's arm in order to apply the shirt, and the resident then was observed to immediately retract the right arm to its prior position. RPN #114 had difficulty raising the resident's arm above the resident's head and required the RPN to use both hands and lift vigorously in upward motion to apply the resident's shirt sleeve. Then RPN #114 was observed to push the resident in a forward motion, from the back of the resident's chair to pull the shirt along the resident's back. No communication with the resident was observed. The RPN #114 was then observed with both hands to be pulling the resident's left arm in an upward motion, to apply the other sleeve of the shirt. Resident #001 was observed to try to restrain with the right hand, RPN #114 from pulling the left arm in upward motion, however it was observed that PSW #113 restrained the resident's right hand from grabbing RPN #114.

Resident #001 was admitted to the home on a specified date with several medical diagnoses. The resident's most recent Minimum Data Set (MDS) documented the resident as having memory impairment with severely impaired decision making ability.

The resident is dependant on nursing staff for positioning and transfers as well as personal care provision for dressing, hygiene and continence care with two staff members. The resident's plan of care documented that resident #001 had responsive behaviours of resisting personal care and required one staff member to hold the resident's hands and talk to the resident in order to distract the resident while the other staff member provides the resident personal care. The resident's plan of care for functional capacity documented generalized deconditioning affecting the resident's flexibility of specified upper and lower body joints and requires active assisted range of motion. Resident's plan of care identified that the resident required interventions related to approach for responsive behaviours, including speaking to the resident and giving clear information of what nursing staff were about to do before positioning and transfers, to ease the resident's agitation and resistance.

On a specified date, PSW #113 indicated to Inspector #547 to be a regular PSW for the resident during a specified shift and was one of the nursing staff members observed in the video clip. PSW #113 indicated the resident is not always awake when they do their last round during the specified shift, however they are to wake the resident to wash and transfer the resident to a wheelchair for falls prevention. PSW #113 indicated when the resident is awake during their last round, that this is a trigger for falls as the resident tries to get out of bed. PSW #113 indicated that the resident tends to be stiff and more resistive to care with contracted arms and legs if they have to wake the resident to provide personal care. PSW #113 indicated after watching the video provided by the family, that the vigorous action of pulling the resident's arms in an upwards motion to get the resident's upper body dressed, was not as per the resident's plan of care for decreased mobility. PSW #113 further indicated they did not communicate with the resident or hold the resident's hands during personal care.

As such, the residents plan of care was not provided to resident #001 on this specified date for the resident's personal care and dressing needs, responsive behaviour approaches or the resident's needs for reassurance related to anxiety. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

On a specified date, resident #002 participated in a dinner organized by the activities group. Resident #002 swallowed a food item that became lodged in the resident's throat and was sent to the hospital where the food item was dislodged and removed.

Resident #002 was admitted to the home on a specified date with several medical diagnoses.

Resident #002's health care records at the time of this incident indicated the resident was on a diabetic diet with cut up texture that was assessed on a specified date by the home's Registered Dietitian. This diet texture was still in place and an active intervention in the plan of care. Resident's plan of care indicated the resident had impulsive responsive behaviours.

The Activity Coordinator indicated to Inspector #547 during an interview, to have been with resident #002 for the dinner activity on this specified date. The Activity Coordinator indicated they follow a list of residents for each floor that are interested in an activity, and monthly received a Kardex for each floor from the Registered Dietitian in the home that identified resident's diets, textures as well as special instructions. The Activity Coordinator recalled the resident was identified as cut up food and finger foods PRN (as required) on the Kardex. The Activity Coordinator indicated to have been the staff member coordinating this activity a specified date. The Activity Coordinator indicated to have recalled placing a plate of food for resident #002 on the table in front of the resident, and then proceeded to serve the other residents in the room at this activity. The Activity Coordinator returned to cut up the resident's food and noticed that there was a piece of food missing from the plate. The Activity Coordinator observed the resident had a piece of this specified food in the resident's left hand, and asked if the resident had swallowed a piece of the specified food item, and the resident indicated yes. The Activity Coordinator indicated the resident was not choking or in any distress but that the resident was salivating. The Activity Coordinator brought the resident back up to the resident's unit to be assessed by the registered nurse. The resident was then sent to the hospital and required to have a foreign object removed from the resident's throat. The Activity Coordinator thought the resident was approved to eat finger foods, and did not cut the food item before serving the resident's plate. The resident's plan of care identified food to be cut-up.

As such, the resident's care related to dietary texture assessed for the resident dietary needs was not provided to resident #002 at the dining activity on this identified date as specified in the plan and the resident choked on a specified food item. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in their plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #002.

On a specified date, the home sent the Director, a Critical Incident Report (CIR) regarding an incident that caused an injury to resident #002 for which resident #002 was taken to hospital that resulted with a specified injury. The CIR indicated the resident had no specified incidents but was recently diagnosed with a similar injury.

Resident #002's health care records indicated the resident was admitted to the home on a specified date with several medical diagnoses with paralysis to specified body parts. Resident #002's plan of care prior to this incident indicated the resident requires the use of a specified piece of equipment for transfers with two nursing staff assistance. The resident requires total assistance for dressing, bathing, and considerable assistance for repositioning the resident in bed with two nursing staff or more. The resident requires the use of a specified type of chair with assistance of one staff member. The resident requires a specified piece of equipment added to this specified chair in order to rest the resident's paralysed limb. The resident has impulsive behaviours with verbal and physical aggression. The resident's flow sheet tools completed by Personal Support Workers (PSW) for this specified date, indicated the resident had total assistance of two staff members on all shifts for: bed mobility, transfers, dressing, continence care and personal hygiene. The resident's behaviour tool documented the resident was mad at self and others with verbal and physical aggression with resistance to care on specified shifts.

The resident's positioning schedule tool had no documented repositioning on the specified shift, yet the continence care flow sheet documented the resident's brief was changed and the physical care flow sheet documented total care of two staff members. The resident was repositioned approximately every two hours as required. The bath flow sheet documented resident #002 received a bed bath on the day shift and that the resident's skin was intact and no bruising, redness or edema were noted.

Resident #002's progress notes for this specified date, had documentation on one specified shift only at near the end of the shift which indicated the PSW staff reported to the registered nursing staff that the resident had an injury observed to a specified area when they provided the resident personal care. The charge Registered Nurse (RN) documented resident #002 demonstrated facial grimacing and verbal and physical aggression upon manipulation of the specified area and assessed the resident's injury. The resident was transferred to hospital at a specified time, and returned to the home over 12 hours later diagnosed with a specified injury to a specified area.

PSW #105 indicated to Inspector #547 during an interview, to have been the staff member that cared for the resident during the specified shift before the resident's injury was noted. PSW #105 indicated that the resident's shift was uneventful, that they had provided the resident a bed bath. PSW #105 indicated that the resident was placed into a specified chair with specific limb supports, and no injury was noted on this specified shift. PSW #105 further indicated that the resident cannot lift or move specified body parts, which is why the resident has specific pieces of equipment to support specified body parts.

The resident's Substitute Decision Maker (SDM)indicated to Inspector #547 during an interview, to be quite concerned about the resident, as this is the second injury to specified body parts over the last few months. The resident's SDM indicated that the resident cannot mobilize the affected body parts independently and that these injuries were related to how the nursing staff reposition and transfer the resident.

PSW #106 indicated to Inspector #547 during an interview that the resident cannot lift or move the specified body parts without assistance by a staff member. PSW #106 indicated that personal care of bathing, repositioning, dressing and continence care can be difficult for nursing staff as resident #002 is unpredictable and known to be physically aggressive towards staff during care.

Inspector #547 observed three nursing staff members provide the resident personal care

while in bed. One PSW was standing to the resident's left side, and another to the right side. The third nursing staff member was there to assist in preparing clothing, washing and assistance with positioning and turning of the resident. Resident #002 was observed to have capacity to use two specified body parts to assist in turning to a specified side using specified equipment attached to the resident's bed frame. The three nursing staff had difficulty in turning the resident to a specified side to support specified body parts to wash and dry the resident, change of the resident's continence product and applying a specified piece of equipment. The nursing staff were observed to ask the resident to turn towards to the resident's affected side, however the resident is unable to transfer or turn self to this specified side due to paralysis.

As such, the resident's injuries can only have occurred during unsafe transferring or positioning techniques when staff were assisting the resident, since the resident cannot mobilize specified limbs independently without assistance from nursing staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Resident #002 was admitted to the home on a specified date with several medical diagnoses including dementia. Resident's health care record indicated the resident has been having increased discomfort to a specified body part since a specified date, that required pain medication to be ordered for the resident's comfort measures.

RN #108 indicated to Inspector #547 during an interview regarding resident #002's pain control management, that resident #002 has been refusing oral medications, however the nursing staff have started placing the crushed medication inside a specified food item that the resident enjoyed. RN #108 indicated to have asked RPN #109 to provide the specified medications to the residents on the unit.

RPN #109 indicated to Inspector #547 that RN #108 gave directions that resident #002 required pain medication as the resident had expressed pain to a specified area. RPN #109 indicated that resident #002 refuses medications, and that the medications had to be crushed and hidden in food to ensure that the resident takes the prescribed medications. RPN #109 indicated the following: the prescribed medication was crushed and mixed into the specified food item. The food item medication mixture was then placed into the food item and given to the resident for consumption.

RPN #109 indicated to Inspector #547 that the resident had already received a meal tray and had been provided the food item with the medication. Inspector #547 asked RPN #109 if the resident accepted the oral medication in the food item and RPN #109 said yes.

Inspector #547 went to resident #002's bedside two minutes after the interview with RPN #109 and PSW #107 was observed trying to feed the resident food. PSW #107 indicated that the resident is refusing food on the specified meal tray. PSW #107 had a bowl that contained two specified food items. PSW #107 indicated to Inspector #547 that the resident consumed part of a specified food item, but later spit it out. Inspector #547 asked if this was the specified food item that had medicated mixture inside it, and PSW #107 indicated yes. PSW #107 indicated RN #108 gave instructions that the specified food item should be fed to the resident first, as it contained medication. PSW #107 indicated the resident spit out the food item, therefore the PSW removed the medication mixture and placed it on a piece of a specified food item and gave it to the resident. PSW #107 indicated that the resident ate the specified food item, however the resident refused to eat anything else off the meal tray. PSW #107 indicated to Inspector #547 that there were no registered nursing staff present when the medication mixture was provided to

the resident. PSW #107 indicated the food item was provided with the resident's meal tray by the registered nursing staff. The PSW further indicated that PSW's do not give residents oral medications.

RPN #109 reported to Inspector #547 to have dispensed and crushed the prescribed medications into a specified food item for resident #002. RPN #109 indicated being aware that PSW #107 was provided the food item that contained crushed medications with the resident's meal tray. RPN #109 indicated being aware that PSW staff are not to be provided prescribed medications to administer to residents.

RN #108 indicated to Inspector #547 of being aware that PSW #107 was provided the food item that contained the crushed medication with the resident's meal tray. RN #108 indicated that the resident required medication to be hidden into food, and PSW #107 was going to feed the resident the specified meal. RN #108 indicated being aware that PSW staff are not supposed to administer prescribed medications to residents unsupervised by a registered nursing staff member of the home. [s. 131. (3)]

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 PSW's do not administer any oral medications to residents in the home, to be implemented voluntarily.

Issued on this 20th day of March, 2018

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

Original report signed by the inspector.