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_0003	001543-18	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

LISA KLUKE (547)

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

This complaint inspection was regarding a concern for medication administration and the provision of the resident's plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Managers for Resident Care (PMRC) and Personal Care (PMPC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), a family member and a resident.

In addition, over the course of the inspection, the inspector reviewed resident health care records, staff work routines, observed resident rooms and common resident areas, requested a written complaint document provided to the home 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
Reporting and Complaints

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 was provided to resident #001 regarding personal care provision, as specified in the plan.

On a specified date, a written complaint was provided to the home by resident #001's Substitute Decision Maker(SDM) regarding the provision of personal care to the resident on an earlier specified date at specified times. The resident's SDM provided picture of a video clip in this written complaint, that demonstrated the resident received personal care and hygiene with continence care by two staff members, and one of these staff members was male.

Resident #001 was admitted to the home on a specified date with several medical diagnoses including Alzheimer's type dementia. Resident #001's plan of care indicated the resident requires assistance of one nursing staff member for personal hygiene and continence care and specified that personal care is not to be provided by male nursing staff members for responsive behaviour needs and preferences.

Inspector #547 reviewed resident #001's health care records for this specified date with incident. The behaviour tool documented resident #001 had no behaviours during this shift. The physical functioning tool (Activity of Daily Living (ADL) legend indicated personal care and hygiene which included perineal care, documented with the letter T that signified total care was provided and the number 1 which indicated resident #001 required assistance by one staff member that shift. Resident #001's progress notes for the previous shift summary, indicated the resident resisted personal care of hygiene and continence care, however nursing staff applied the approaches identified in the plan of care, and the resident received personal care of hygiene for continence care at a specified time in that shift. RN #115 documented for the specified incident shift summary, that the resident slept well that shift and care was provided to the resident with little resistance.

The PMRC indicated to inspector #547 during an interview, that the PSWs are supposed to provide resident #001's personal care by one female nursing staff, and if difficulties arise in the provision of personal care due to responsive behaviours, the PSW is to reattempt care at a later time. At that later time, the PSW will attempt to provide personal care again, and if responsive behaviours arise again by resident #001, then the PSW is to leave the resident and return to attempt with two nursing staff members. The PMRC indicated that each nursing staff member is required to be female for this resident's responsive behaviour needs and preferences.

As such, resident #001 was provided personal care including hygiene and continence care during the specified shift on this specified date, that was not in accordance to the resident's plan of care. [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 LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward a written complaint by resident #001's Substitute Decision Maker (SDM) received on a specified date concerning care provided to resident #001 during a specified shift to the Director.

Resident #001's SDM attended a meeting in the home on a specified date and provided a written complaint to the Licensee. This written complaint identified concerns regarding personal care provision to resident #001 on a specified shift of a specified date. The written complaint further identified concerns regarding a drug that was administered to resident #001 on another specified date that was not in accordance with the directions for use specified by the prescriber.

The Program Manager for Personal Care (PMPC) and the Administrator indicated to Inspector #547 that they forwarded this written complaint on a specified date after the inspection began in the home, that was not immediately forwarded as required by this section. [s. 22. (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 the Licensee immediately forwards written complaints concerning the care of residents or the operation of the long-term care home to the Director, 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. (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 resident #001 in accordance with the directions for use specified by the prescriber.

Resident #001's Substitute Decision Maker (SDM) provided the Licensee with a written complaint regarding the provision of care to the resident at a specified time on a specified date. The written complaint specified that RN #115 provided resident #001 with a specified medication tablet for a specified reason at a specified time, however not as per the directions specified in the resident's physician orders.

Resident #001 was admitted to the home on a specified date with several medical diagnoses including Alzheimer's type dementia.

Inspector #547 reviewed resident #001's health care records that indicated in the Medication Administration Record (MAR), that resident #001 was prescribed this specified medication to be given to the resident as required for a specified procedure to be completed.

The resident's MAR for this specified month, had the prescribed order documented for

this medication with directions for use as give this specified medication as required for a specific procedure to be completed. Time documented as PRN meaning as required. Nursing staff initials were documented on this specified date. PRN/ Medication/ Treatment notes on the reverse side of this MAR document indicated for this specified date and time, this specified medication was provided to resident #001 for another specified reason. The Medisystem document for controlled medications for resident #001 for this specified medication as a dose was administered to the resident at a specified time. The resident's health records did not have this specified procedure documented as performed on this specified date.

The behaviour tool documented nervousness behaviour on the shift prior to this specified time. This tool documented the resident had repetitive verbal requests, always mad at self or others and repetitive movements.

Resident's progress notes documented on the following shift of this specified date and time when the specified medication was administered to the resident by the unit charge RN #108, that the resident had specified side effects from having the earlier specified medication. RN #108 documented to have noticed the MAR for the resident, and that the resident received this specified medication at a specified time without a prescription and an incident report was completed. It was noted there were no progress notes related to the charge RN #115 on the specified shift for the reason of the medication administration. [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 the home, in accordance with the directions for use specified by the prescriber, 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.