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
Oct 24, 2018	2018_619550_0016	017924-18	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

JOANNE HENRIE (550)

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): October 12, 15, 16, 17, 18 and 19, 2018.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Program Manager of Personal Care (PMPC), the Program Manager of Resident Care (PMRC), the Hospitality Manager, the acting Activity Coordinator, an Enterostomal Nurse (E.T. nurse) several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and several residents.

In addition, the inspector reviewed resident health care records, observed resident care and services and resident interaction.

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. (1)	CO #003	2018_548592_0008	550

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 plan of care set out clear directions to staff who provide direct care to the resident.

During an interview, PMPC #103 provided inspector #550 with a document containing a list of all the residents in the home identified with skin integrity issues. The inspector noted documented that resident #002 had a full thickness wound to a specific body part with a specific type of dressing to be changed at a specified time.

The inspector reviewed the documentation in resident #002's health care records. It was documented on the wound assessment tool used to assess the resident's wound on five specific dates that the wound was at a specified stage and the directions for the dressing indicated a type of dressing was to be applied to the two wounds.

The current plan of care for resident #002 indicated the presence of two wounds to a specified body part. The first intervention documented for skin integrity indicated the frequency of the dressing change. The seventh intervention documented indicated a different type of treatment for the wound with a different frequency of the dressing change.

During an interview, the Enterostomal (E.T.) nurse told the inspector the wound was on a specific body part and was caused by a specific medical condition. The medical condition was now controlled but there were still residual effects. There were two wounds to that specific body part before but now there was only one wound. The nurse indicated that because the wound was a full thickness wound, it could appear as two different stages,

other than was was documented on the wound assessment tool, depending on the appearance of the wound. The current treatment was a different treatment than what was documented in the care plan with a different frequency of change.

As evidenced above, the plan of care for resident #002 does not set out clear directions to staff who provide direct care to this resident. [s. 6. (1) (c)]

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

Resident #002 was identified by the PMPC #103 has having a full thickness wound to a specific body part. PMPC described a specific type of treatment for this wound and to be changed at a specific frequency.

The last assessment by the Enterostomal (E.T.) nurse described the same treatment as indicated by the PMPC.

On October 16, 2018, inspector #550 observed while RN #100 changed the dressing to resident #002's wound. The inspector observed that the old dressing covering the wound that was removed by the RN was not the type of dressing specified on the E.T. nurse assessment. The RN did not perform the dressing change as per directions from the E.T. nurse and applied a different type of dressing to cover the wound. When the inspector questioned RN #100 about the the type of dressing they had used to cover the wound, the RN stated that they did not have the type of dressing recommended by the E.T. nurse, that they had used the same type of dressing that was on the resident's wound earlier and that they had been using this type of dressing for a while now. When the RN returned to the nursing station RPN #102 showed the RN the proper dressing to be used for resident #002's wound. The RN then told the inspector they were going to change the dressing and replace it with the proper type of dressing.

As evidenced, the care set out in the plan of care was not provided to resident #002 as specified in their plan regarding the treatment of the wound. [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 plan of care set out clear directions to staff who provide direct care to residents and to ensure that the care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

According to O.Reg 79/10, s. 48.(1), every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Resident #004 has had an open wound at a specified stage to a specific body part. E. T. Nurse #107 and PMPC #103 told the inspector that for medical reasons, this wound would possibly never heal.

A review of the resident's health care records determined that as part of the ongoing treatment of this wound, the Registered Dietician had ordered a protein supplement to be administered by mouth to the resident three times per day. This treatment was re-ordered in the Physician's Order Review by the resident's physician three months earlier. During an interview, RPN #102 told inspector #550 that the resident is administered a protein supplement at mealtime and this is documented in the Medication Administration Record (MAR). The inspector reviewed the MAR for the months of October, 2018 and was not able to find any documentation related to the administration of the protein supplement three times daily. The inspector and RPN #102 reviewed the MAR for the months of August and September and were still not able to find documentation related to the administration of the protein supplement.

The administration of the protein supplement three times daily which is an intervention for the treatment of resident #004's wound was not documented. [s. 30. (2)]

2. Inspector #550 observed that resident #003 had a pressure relief air mattress on their bed with the dial set at low pressure. During an interview, RN #106 told the inspector the resident has a pressure relief air mattress on their bed for the management of their wound. The inspector reviewed the resident's actual plan of care and was not able to find documentation indicating the use of a pressure relief air mattress.

The pressure relief air mattress which is an intervention that is part of the treatment to manage the resident's wound, was not documented. [s. 30. (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 interventions taken under a program are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed at a minimum, twice weekly by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

On October 16, 2018, during an observation of resident #002, inspector #550 observed the resident had long toe nails. RN #100 told the inspector that PSWs are responsible for cutting resident's toe nails on their bath days. Inspector #550 reviewed the bath list for the unit in the flow sheet binder at the nursing station. It was documented that resident #002 was scheduled to have a bath twice per week on two specified day. The inspector then reviewed the documentation in the "Dossier de surveillance et d'observation MDS – Bain" form for resident #002 for the months of September and October 2018. In October, resident #002 should have had a bath on four specified dates and there was documentation to indicate that the resident received their bath on three specified dates. In September 2018, the resident should have received a bed bath on nine specified dates and there was no documentation to indicate the resident received a bath on two specified dates. [s. 33. (1)]

2. According to the bath list in the flow sheet binder at the nursing station, resident #005

was to have a bath on two specified dates. The inspector reviewed the documentation in the "Dossier de surveillance et d'observation MDS – Bain" form for the months of September and October, 2018 for resident #005. For two specified weeks in September, it was documented the resident had a bath each week. For a specified week of October, it was documented the resident had one bath for that week. [s. 33. (1)]

3. According to the bath list in the flow sheet binder at the nursing station, resident #006 is to have a bath on two specified days. The inspector reviewed the documentation in the "Dossier de surveillance et d'observation MDS – Bain" form for the months of September and October, 2018. For two specified weeks in September, it was documented the resident had a bath each week. For a specified week of October, it was documented the resident had one bath for that week.

RPN #102 told the inspector that they have been short staffed on the unit and because of this the residents did not always have their baths as scheduled. When they are short staffed, they try to re-schedule the residents' bath but this is not always possible when they are short staffed for a few days in a row. According to the assignment sheet provided by RPN #102, they were short staffed for two specified dates on this unit.

During an interview, the Program Manager for Personal Care (PMPC) #103 and the Program Manager for Resident Care (PMRC) #104 both indicated that residents are to receive two baths per week at a minimum. When they are short staffed, the PSWs are instructed to give complete bed baths to the residents who are scheduled to have their bath that day. [s. 33. (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 residents are bathed twice per week at a minimum,, to be implemented voluntarily.

WN #4: 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 resident #003 who was exhibiting altered skin integrity, including wounds was assessed by a registered dietitian (R.D.) who is a member of the staff of the home.

Resident #003 was identified by the PMPC #103 and RN #106 has having a wound to a specified body part. A review of the documentation in the resident's health care records and an interview with E. T. nurse #107 identified that this resident's wound was first noted on a specified date.

Inspector #550 reviewed the documentation in the resident's health care records and was not able to find any documentation indicating the resident was referred to the R.D. or that a referral had been filled out and submitted to the R.D. to assess the resident. During an interview, RN #106 confirmed to inspector #550 that resident #003 was not referred to the R.D. further adding that they were going to complete and send a referral to the home's R.D.

The PMPC indicated the resident was not referred to the RD when the wound was discovered. [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 residents who are exhibiting altered skin integrity including wounds are assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

On June 21, 2018, the following compliance order (CO) #003, from inspection number 2018_548592_0008 was made under LTCHA, 2007, c. 8, s. 19:

The licensee must be compliant with s. 19 (1) of the LTCHA, 2007.

Specifically, the licensee shall:
1. Provide additional training to all managers working at Centre d'Acceuil Champlain in relation to their role and responsibilities related to the mandatory reporting of suspicions of neglect of a resident that resulted in harm or risk of harm to a resident;
2. Ensure that the planned interventions to meet the skin care needs of residents at risk for altered skin integrity are provided to residents by registered nursing staff as specified in the written plan of care and the applicable licensee's policies;

3. Implement enhanced monitoring processes to assess the effectiveness of the nursing care delivery on all units to ensure that all residents are provided with the treatment, care and assistance required to maintain their health, safety and overall well-being; and
4. Document the results of this monitoring process and the actions taken by the Long-Term Care home Senior Leadership Team of the City of Ottawa to address identified problems.

The compliance date was February 14, 2018.

A follow-up inspection was conducted on October 12 to 19, 2018 where inspector #550 was able to identify that the licensee had completed step(s) 1, 2 and 4 in CO#003. The inspector further noted that step 3 was not completed.

During an interview, the PMPC #103 told inspector #550 that they were responsible for the implementation of the enhanced monitoring process for skin and wound care. The PMPC showed the inspector a document with the name of the resident, the skin issue, the location, the treatment, the frequency of the treatment, the date, evaluation and the state of the skin issue. The PMPC told the inspector that in July and August, this monitoring process was done daily but it was now done weekly. In the morning they would look through the nursing report for each unit and note all issues regarding skin and wound care for residents. The PMPC would then go to each unit and make sure that each resident identified with skin/wound issues was referred to the RD, the appropriate treatment was documented in the Marsheet and signed by the registered nursing staff as required, a skin assessment was completed by the registered nursing staff using the wound assessment tool, the wound was reassessed at least weekly by the registered nursing staff, a repositioning flow sheet was in the flow sheet binder and signed for residents who required to be on the repositioning program. The resident was referred to the ET nurse when the wound would not improve or would deteriorate. The resident was referred to OT or PT for services as required. When the PMPC noted that something was not completed, they would assign this to be completed by the registered nursing staff that day.

During the course of this inspection, and as identified throughout this report, inspector #550 identified issues where residents were not provided with the required treatment, care and assistance required to maintain their health and well-being.

Resident #002's plan of care did not provide clear directions to staff who care for the resident as identified in WN #1.

The care provided to resident #002 was not provided as specified in the plan of care as identified in WN #1.
Actions taken including interventions under the skin and wound program were not documented for resident #003 and #004 as identified in WN #2.
Resident #002, #005 and #006 were not provide with a bath two times per week as identified in WN #3.
Resident #002 was not provided with basic foot care services, including the cutting of toenails as identified in WN #6.
Resident #003 who has an open wound was not referred to the home's RD as identified in WN #4.

The Licensee failed to complete step 3 of CO #003. Although an enhanced monitoring process was implemented to assess the effectiveness of the nursing care delivery on all units it was not effective in ensuring that the residents were provided with the treatment, care and assistance required to maintain their health, safety and overall well-being. [s. 101. (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 they comply with every order made under this Act, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receive preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

During an observation of resident #002, inspector #550 observed the resident had long toe nails. RN #100 and RPN #102 told the inspector that PSWs are responsible for cutting residents’ toe nails on their bath days and document this in the "Dossier de surveillance et d'observation MDS – Bain” form unless the resident has foot care done by the foot care nurse. The inspector reviewed resident #002’s written plan of care and observed that it did not address the cutting of nail care for the resident. The progress notes were reviewed for the months of September and October and there were no notes indicating foot care had been provided to the resident by a foot care nurse. The inspector reviewed the "Dossier de surveillance et d'observation MDS – Bain” form for resident #002, for the months of September and October, 2018 and observed that there was no documentation indicating resident #002 had their toe nails cut in either months. Later, RN #100 told the inspector that PSW #105 had gone to cut this resident’s toe nails.

During an interview, PMPC #103 and PMRC #104 told the inspector that PSWs are to assess the residents’ toe nails on their bath day, cut them if required and document this care on the "Dossier de surveillance et d'observation MDS – Bain” form.

As evidenced, resident #002 was not provided with basic foot care services including the cutting of toenails. [s. 35. (1)]

Issued on this 24th day of October, 2018

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

Original report signed by the inspector.