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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2018	2018_683126_0017	017332-18, 018896-18	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

LINDA HARKINS (126)

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): August 27, 28, 29, 30, September 4, 2018

During the course of this inspection the following logs were inspected:
Log # 017332-18 and log #018896-18 related to allegations of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Program Manager for Personal Care (PMPC), the Program Manager for Resident Care (PMRC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), the temporary Quality Improvement Nurse, several Personal Support Workers (PSWs), one family member and several residents.

During the course of the inspection, the inspector reviewed residents' health care records and relevant policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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

- **1 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	Légende 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who requires continence care

products have sufficient changes to remain clean, dry and comfortable.

Resident #002 was admitted to the home with several diagnosis. Resident #002 requires total assistance for continence care and exhibit responsive behaviors on a daily basis.

On a specific date, resident #022 was prepared for the night by the evening staff around 2030 hours who changed the incontinence product at that time. After the change, resident #002 was exhibiting responsive behaviors and was transferred from the bed to the wheelchair (w/c) and was brought to the nursing station for close monitoring.

On that specific date, during the night shift, resident #002 was kept at the nursing station exhibiting agitation and responsive behaviors. The night shift Personal Support Workers (PSWs) made several attempts to decreased resident's #002 responsive behaviors by using different interventions which were ineffective. Resident #002 had not received continence care during that shift.

Discussion held with Personal Support Worker (PSW) #105, who worked on that specific night shift, indicated that at the beginning of the shift, resident #002 was at the nursing station and exhibited responsive behaviors most of the night and only slept approximately 1 hour during that shift. PSW #105 indicated that continence care was not provided during the night and that at the end of the shift, resident #002 appeared to be dry and no offensive odors were noted.

At the beginning of the day shift, resident #002 was still at the nursing station exhibiting responsive behaviors.

Discussion held with Registered Nurse (RN) #106 who worked on that specific day, indicated that at the beginning of the day shift, resident #002 was in the w/c and appeared dry and was no offensive odors were noted. RN #106 indicated that at the morning report, they were informed that resident #002 had responsive behaviors during the night but they were not informed that the resident did not received continence care.

Discussion held with PSW #107 who was working that specific day shift, indicated that they noticed that resident #002 was at the nursing station sitting in the w/c. PSW# 107 indicated that resident #002 appeared dry and clean and no offensive odors were noted. PSW #107 indicated that they did not feed resident #002's breakfast and later that morning after the morning break, went to the room to assist with the care of the resident. At that time, resident #002 was in the room in the presence of the Substitute Decision

Maker (SDM) and another PSW.

Discussion held with Administrator #100 who indicated that the day staff who worked on that specific day were interviewed and indicated that the nursing staff stated that resident #002 appeared dry when the resident was brought to the dining room for breakfast and that the resident was changed after breakfast.

Resident's #002's SDM arrived on the unit that morning and resident #002 has been incontinent of urine and bowel.

As such, the licensee has failed to ensure that resident #002 was changed from the evening to the next morning and did not received sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 resident who requires continence care products have sufficient changes to remain clean, dry and comfortable., to be implemented voluntarily.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.