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 24, 2018	2018_583117_0020	029383-18, 030685-18, 032548-18	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

LYNE DUCHESNE (117)

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): December 17, 18 and 19, 2018

The following inspections were conducted concurrently during this Follow-Up Inspection:
- Log # 032548-18: Follow Up Inspection for compliance order CO #001 related to O.Reg. s. 114 (1) issued under Inspection # 2018_683126_0018 with a compliance due date of November 20, 2018
- Log # 029383-18: Critical Incident Report (CIS # M511-000054-18) related to incident of alleged staff to resident neglect
- Log # 030685-18: Critical Incident Report (CIS # M5111-000056-18) related to a missing or unaccounted for controlled substance

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager of Personal Care (PMOPC), Quality Manager, several Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

During this inspection, the inspector(s) reviewed several residents' health care records, reviewed several residents' medication orders and medication administration records, observed a medication administration pass and several medication carts including the separate locked areas for controlled substances, reviewed the registered nursing education program related to the medication management system and processing of medical orders, reviewed the medical order verification/reconciliation/administration audits, reviewed several medication incident reports, and reviewed the processes related to laboratory and external x-ray services.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication

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)**

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
O.Reg 79/10 s. 114. (1)	CO #001	2018_683126_0018	117

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. (Log # 029383-18)

Resident # 003 was admitted to the home in 2018. The resident was identified as utilising a walker to aide with decreased mobility, as well as other co-morbities. On a specified day in 2018, the resident expressed pain and discomfort to both knees. The resident's mobility decreased over the next two days where by the resident required the aide a wheelchair and a mechanical lift for transfers. Two days later, the attending physician assessed the resident. Medical orders were written for X-ray, blood work and cultures.

The day the orders were written, RN #106 actioned the medical orders. A fax was sent to the mobile x-ray service provider and two requisitions were written for the requested blood and culture laboratory tests. Unit shift report indicated that the requested culture sample had not been collected and required to be done. As per RN #106, the requisition for the blood work was placed in the laboratory service provider box, with several other requisitions to be actioned the next day, for when the laboratory service provider technician comes for one of their bi-weekly scheduled visits to the home. The evening RN #107, said to the inspector that they did see the requisition for the culture, however was unable to collect the requested sample. This was noted on the 24-hour shift report.

The next day, the mobile x-ray service provider took the requested x-rays. No injuries were identified on the x-rays. The laboratory service provider technician collected several blood work requisitions. The requisitions included resident #003's requested blood work as well as blood work requisitions for several other residents. RN #106 said to the

inspector that the laboratory technician had informed them at that time that they could action only part of the requisitions as they did not have all of the required equipment to do all of the requested work. RN #106 said that the technician completed several requisitions but did not verify to see if the requisition for resident #003 had been done. RN #106 also said that they had seen the culture requisition at the nursing desk, had not been able to collect the requested culture sample and noted this on the 24-hours shift report. The evening RN #107 said to the inspector that they did not see the requisition for the requested culture. They did not inquire as to determine if a sample had been collected and sent for analysis.

A review of the resident's health care record as well as the unit's 24-hour shift reports indicated that there were no notes as to the status of the requested blood work and culture for the next three days. On the fourth day post medical order, unit RN #115 found resident #003's culture requisition amongst other documents at the nursing station and placed the requisition in a file for it to be actioned on the Monday. There are no notes that day's and the next day's the 24-hour shift report nor in the resident's health care record regarding the status of the culture requisition.

On a specified day, seven days after the initial medical order was written, the laboratory service provider sent a fax to the unit nursing station indicating that resident #003's blood work, with associated results attached, had been done on the previous day as part of the scheduled laboratory bi-weekly visit days.
That same day, the attending physician assessed the resident and requested another series of tests to be done as the resident's health status was deteriorating. These included blood work and another culture. The requisition for the blood work was noted to have been actioned. No information was found regarding the status of the newly requested culture in either the progress notes or in the unit's 24-hour shift report. There are no notes that day nor the next day regarding the culture sample being collected as per the new requisition. The evening RN #107 said to the inspector that they did not see the new requisition for the culture. They did not inquire as to determine if a sample had been collected and sent for analysis even though they had signed off on the medical order verification process.

On a specified day in 2018, the attending physician met with RN #106 and the resident #003's substitute decision maker (SDM) to review the resident's health status. It was noted at that time that the requested cultures from nine days and two days prior had not been actioned. New medical orders for a culture and blood work were written and immediately actioned by RN #106. The results for the culture and blood work were

received the same day. The analysis identified changes that were not within therapeutic range of values. The resident was transferred and admitted to hospital for further assessment and treatment.

RNs #106 and #107 said to the inspector that they had not followed up on the status of the requested blood work and culture ordered on a specified day in 2018 and then on the culture requisition done seven days later. They both said that they did not document the status of the requested tests in the unit 24-hour nursing report. The Director of Care (DOC) and Program Manager of Personal Care (PMOPC) conducted a review of the above incident with RN# 106, #107 and #115. RN #115 had indicated to them that they did not think that they could collect the requested culture on weekends and did not communicate with other nursing staff that a culture was still required to be collected. The DOC and PMOPC said to the inspector that the home does have a process for ensuring that requested tests are actioned. Nursing staff are to document in the home's 24- hour nursing report any tests to be done and required follow ups. This is to ensure that there is ongoing communication and collaboration between the various shifts to ensure that requested test are actioned and completed as per medical orders. The DOC and PMOPC said that there were gaps in the communication and collaboration between registered nursing staff in regards to resident #003's requested culture and blood tests ordered on a specified day in 2018 and for the second culture requisition, ordered seven days after the initial order. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 24th day of December, 2018

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

Original report signed by the inspector.