Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
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Telephone: (613) 569-5602
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347 rue Preston bureau 420
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 2020	2020_818502_0005	022481-19, 022482-19, 024457-19, 024480-19, 000952-20, 002817-20	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

JULIENNE NGONLOGA (502), 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): February 11, 12, 14, 18, 19, 20, and 21, 2020.

During the course of the inspection, the following Critical Incident System (CIS) report were inspected during:
- CIS # M511-000064-19 (log #024480-19), #M511-000063-19 (log #024457-19) related to falls.
- CIS #M511-000001-20 (log #000952-20) related to self-harm.
- CIS #M511-000005-20 (log #002817-20) unexpected death of resident

Follow-up inspection (logs #022481-19 and 022482-19) for CO #001 and CO #002 of inspection report #2019_818502_0022 was conducted concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Personal Care (PMPC), the Program Manager of Resident Care (PMRC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Behaviour Support Ontario (BSO) Consultant, Physician, Physiotherapist (PT), Manager of Activity Program, Coordinator of unit Activity Program, Food Service Supervisor, Registered Dietitian (RD), Dietary Aide, Resident Assessment Instrument-Minimum Date Set (RAI-MDS) Coordinator, scheduling clerk, residents and a family member of the residents.

During the course of this inspection, the inspector(s) the inspectors observed resident care, observed staff and resident interactions, interviewed staff and substitute Decision Maker (SDM) and reviewed the residents' health care records, staff schedules, the licensee investigation notes and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Responsive Behaviours
Safe and Secure Home

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 55.	CO #001	2019_818502_0022	502
LTCHA, 2007 S.O. 2007, c.8 s. 6. (9)	CO #002	2019_818502_0022	502

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home was a safe and secure environment for residents #001 and #002.

1. The Ministry of Long-Term Care received a Critical Incident System (CIS) Report

related to self-harm. The CIS indicated that on an identified date, resident #001 attempted self-harm in a specified home area.

Review of resident #001's progress notes indicated that during an identified period, the resident expressed desire to self-harm on three occasions prior to the incident.

Review of the resident's written plan of care indicated that the resident had a history of self-harm thoughts prior to their admission in the home. The plan of care directed staff to remove harmful objects within reach and search the resident's room to remove them.

The plan of care did not identify other areas in the home that have harmful objects, and where the resident stays unsupervised.

In an interview, PSW #104 indicated that they observed resident #001 in an identified home area, naked waste up with identified cutlery in their hands. The resident was forcefully hitting the identified cutlery against their belly and expressing their wish to die. The PSW intervened and called for assistance, as no other staff was present in the area at that time.

In an interview, FSS #107 indicated that at the time of the incident, the servery was closed. The routine was to wash the cutlery at the end of the day, place them on a cart, and wheel them in the identified area. The FSS indicated that resident #001 usually eats their take out in the identified area unsupervised, and they were not informed not to leave the cutlery unsupervised at the end of day when the servery is closed.

In a phone interview, the Manager of Personal Care (MPC) indicated that they scanned the resident's room for harmful objects, but they did not scan other areas in the home where the resident goes unsupervised and they did not share the information with other departments.

The home identified the risk when the resident expressed thoughts of self-harm. The home conducted a search in the resident's room of objects that the resident may use to self harm but did not search other areas in the home where the resident stays unsupervised. Therefore, the area identified above with access to unattended cutlery was not a safe environment for resident #001.

2. The MLTC received a CIS related to an incident of fall. The CIS indicated that on an identified date and time resident #002 attempted to sit unassisted and fell in the

Television (TV) area.

Review of the resident's progress notes and the home's investigation indicated that:
- on an identified date and time, resident #002 had a fall while attempting to sit unassisted on a wheelchair by the nursing station. The breaks on the wheelchair were not applied and the wheelchair did not belong to any resident.
- on the same day resident #002 sat on an armchair in the hallway, removed both shoes and placed them in front of them. PSW #108 noted the risk, put the shoe on the resident right foot and left the left shoe in front of the resident on the floor. The resident got up, tripped on the left shoe, lost balance and fell.
- Few hours later on the same day, the resident had pain with reduced mobility, they were transferred to the hospital, and diagnosed with a specified injury.

On an identified date, the inspector observed four wheelchairs not in use and unsupervised in the hallway of an identified unit, and residents were observed wandering independently in the hallway.

Review of resident #002's current Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment indicated that the resident had short-term and long-term memory deficit and moderately cognitive impairment with poor decisions making skills.

PSW #108 during home investigation stated that they assisted resident #002 to put one shoe on and had pain, then they left the other shoe on the floor and went to redirect another resident. They were waiting for other staff to come out from the shift report to assist resident #002 put on the second shoe.

In an interview, staff #120 indicated that they have two wheelchairs that they used to assist residents ambulate from their care area to the hairdresser. The routine was for the hairdresser to wheel the resident back to their care area after the care. Once staff transfer the resident out of the wheelchair, they will leave the wheelchair in the hallway until the hairdresser pick it up. Staff #120 indicated that they were not being informed when the wheelchair was available to be picked. Therefore, the wheelchair will stay unsupervised in the care area until they have time to retrieved it.

In an interview, RPN #118 indicated that the identified care area had wheelchairs available and were used if a resident had a temporary change in condition including unsteady gait. The RPN stated that those wheelchairs were secured in the unit's storage room. The RPN indicated that the wheelchair in which resident #002 attempted to sit was

not secured with breaks and they did not recall whether the wheelchair belonged to any other resident or it was a loaner wheelchair.

In an interview, the MRC indicated that the loaner wheelchairs were kept in the home's storage in the basement not on the floor. The MRC indicated that they reviewed the home's camera footage and confirmed the PSW #108 statement mentioned above. The MRC acknowledged the area was not safe for resident #002.

Resident #002 was identified to be at high risk of falls due to unsteady gait, poor vision, wandering and fatigue. On an identified day, the resident sustained two falls caused respectively by a shoe left on the floor by PSW #108 and unsecured and unsupervised wheelchair left in the hallway by staff member, as a result the resident had a specified injury. Therefore, the home was not a safe and secure environment for resident #002. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JULIENNE NGONLOGA (502), LINDA HARKINS (126)
Inspection No. / No de l’inspection :	2020_818502_0005
Log No. / No de registre :	022481-19, 022482-19, 024457-19, 024480-19, 000952-20, 002817-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 27, 2020
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Centre d'Accueil Champlain 275 Perrier Street, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jacqueline Roy

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall comply with LTCHA, 2007, s.5.

Specifically, the licensee shall ensure that the home is a safe and secure environment for residents #001, #002 and any other resident in the home as follow:
- ensure that dining room cutlery are stored safely in the kitchen at the end of the day.
- ensure that wheelchairs including loaner wheelchairs are stored safely to prevent access by resident #002 and any other wandering resident in the secured unit when unsupervised.
- ensure that the hallways and any other common area in the secured unit are free from clutter.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for residents #001 and #002.

1. The Ministry of Long-Term Care received a Critical Incident System (CIS) Report related to self-harm. The CIS indicated that on an identified date, resident #001 attempted self-harm in a specified home area.

Review of resident #001's progress notes indicated that during an identified period, the resident expressed desire to self-harm on three occasions prior to the incident.

Review of the resident's written plan of care indicated that the resident had a history of self-harm thoughts prior to their admission in the home. The plan of

care directed staff to remove harmful objects within reach and search the resident's room to remove them.

The plan of care did not identify other areas in the home that have harmful objects, and where the resident stays unsupervised.

In an interview, PSW #104 indicated that they observed resident #001 in an identified home area, naked waste up with identified cutlery in their hands. The resident was forcefully hitting the identified cutlery against their belly and expressing their wish to die. The PSW intervened and called for assistance, as no other staff was present in the area at that time.

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The home identified the risk when the resident expressed thoughts of self-harm. The home conducted a search in the resident's room of objects that the resident may use to self harm but did not search other areas in the home where the resident stays unsupervised. Therefore, the area identified above with access to unattended cutlery was not a safe environment for resident #001.

2. The MLTC received a CIS related to an incident of fall. The CIS indicated that on an identified date and time resident #002 attempted to sit unassisted and fell in the Television (TV) area.

Review of the resident's progress notes and the home's investigation indicated that:
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unassisted on a wheelchair by the nursing station. The breaks on the wheelchair were not applied and the wheelchair did not belong to any resident.
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- Few hours later on the same day, the resident had pain with reduced mobility, they were transferred to the hospital, and diagnosed with a specified injury.

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not recall whether the wheelchair belonged to any other resident or it was a loaner wheelchair.

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Resident #002 was identified to be at high risk of falls due to unsteady gait, poor vision, wandering and fatigue. On an identified day, the resident sustained two falls caused respectively by a shoe left on the floor by PSW #108 and unsecured and unsupervised wheelchair left in the hallway by staff member, as a result the resident had a specified injury. Therefore, the home was not a safe and secure environment for resident #002.

The severity of this issue was an Actual Harm to residents #001 and #002. The scope of the issue was a pattern as two out of three residents reviewed were harmed, and the home had a previous noncompliance to a different subsection of the LTCHA. (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Ottawa Service Area Office