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
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Jul 31, 2020	2020_683126_0016	015088-20	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

LINDA HARKINS (126)

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): July 23, 24, 27, 28, 29, 30, 2020

This complaint was related to an incident of resident to resident abuse and residents safety.
Critical Incident M511-000012-20 was initiated on July 21, 2020. CI inspection # 2020_683126_0015 was concurrently conducted at the same time of this Complaint Inspection.

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), Food Service Supervisor (FSS), Scheduling Clerk, residents and a family member of the residents.

The inspector reviewed the resident's health care records, the licensee's Investigation reports, dining table plan and the Tele Staff Roster. The Inspector observed resident care, observed staff and resident interactions and interviewed residents and staff.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 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 as specified in the plan.

A Critical Incident was submitted to the Director on a specific date in 2020 related to an incident of resident to resident abuse. On that specific date, resident #001 used an electric wheelchair (w/c) and pushed resident #002 to the floor which resulted in a physical injury to resident #002.

Following the incident, resident #001 had one on one monitoring for a period of ten days, which was discontinued by the physician on the 10th day as resident #001 did not exhibit any responsive behaviors since the incident. The one on one was resumed four days after being stopped and was to be implemented on the day and evening shift, as resident required assistance to get out of bed and there is no risk when resident is in bed.

Resident #001's care plan for that specific period up until the inspection was completed and resident #001 was to have one on one for day and evening shift at all time.

In reviewing resident #001's health care record, it was noted that Registered Practical Nurse (RPN) #107 wrote a progress note on specific date, documenting that resident #001 was left unattended at the change of the evening shift. Three days after the incident, Program Manager of Residents Care #114, documented in the progress note, that the camera footage was specifically reviewed that date between 1400hrs and 1600hrs and resident #001 was not seen exiting the bedroom.

Interview held with RPN #107, indicated that the Personal Support Worker (PSW) #111 was a new PSW and that left the side of resident's #001 during the evening report. As soon as they became aware, they ran to resident #001's room and found the resident in the bedroom sitting in the wheelchair (w/c) reading.

Interview held with PSW #111,indicated that on the day of the incident, it was passed 1500hrs, everyone was gone and thought that the other PSW, who was doing one on one for another resident would cover for them. PSW #111 left the unit without waiting to be replaced by the evening one on one PSW.

The licensee failed to provided one on one for resident #001 at all time on that specific date when the evening report was given. [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 was provided as specified in the plan., to be implemented voluntarily.

Issued on this 31st day of July, 2020

[redacted]

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

Original report signed by the inspector.