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

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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
Apr 26, 2022	2022_966755_0005	008138-21, 008421-21, 010256-21, 010446-21, 010506-21, 011837-21, 013243-21, 013690-21, 015552-21, 019432-21, 021165-21, 000563-22, 004667-22	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

MANON NIGHBOR (755)

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): March 9-11, 14-18, 21, 22 and 24, 2022.

The following intakes were completed as part of the Critical Incident System (CIS) Inspection:

Log #008138-21 (CIS #M511-000012-21), log #008421-21 (CIS #M511-000013-21), log #010446-21 (CIS #M511-000018-21), log #010506-21 (CIS #M511-000019-21), log #011837-21 (CIS #M511-000023-21), log #013690-21 (CIS #M511-000026-21), log #004667-22 (CIS #M511-000008-22) related to falls.

Log #000563-22 (CIS #M511-000003-22), log #021165-21 (CIS #M511-000038-21), log #010256-21 (CIS #M511-000016-21), log#015552-21 (CIS #M511-000030-21), log #019432-21 (CIS #M511-000035-21) related to resident to resident responsive behaviours and alleged physical and sexual abuse.

Log#013243-21 (CIS #M511-000025-21) related to alleged abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Manager, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Staff, Scheduler, Support Clerk, Resident Assessment Instrument-Minimum Data Set Coordinator (RAI MDS Coordinator), Activity Representative and residents.

Inspector conducted a tour of the home, observed the provision of care, resident's home areas, staff to resident interactions and resident to resident interactions, preventative measures responding to responsive behaviours, reviewed related health records, policy, licensee's incident investigation packages, Point Click Care and staff schedules.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **1 WN(s)**
- **0 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee has failed to ensure that two residents responsive behaviours, reassessments and interventions and that the residents' responses to interventions were documented in the Behavioural Supports Ontario (BSO) Dementia Observation System (DOS).

The Behavioural Supports Ontario (BSO)- Dementia Observation System (DOS), is a tool used to monitor residents' responsive behaviours, to analyse triggers and plan the next steps. The residents' behaviours observed are documented every 30 minutes for five days.

A) A resident was observed exhibiting responsive behaviours towards residents on their care unit.

A DOS was initiated, after resident exhibited responsive behaviour towards another resident. Step three, the analysis and planning section was left blank.

A DOS was initiated following the resident's responsive behaviours on another date. Three day shifts, an additional period of threeand a half hours, step three, the analysis and planning were not completed.

A DOS was initiated at another time, considering a change in the resident's medication. During the five-day period of the DOS, two day shifts and step three were incomplete.

Following a care conference, it was documented that a DOS would be initiated for five

days. A night shift and an evening shift were not recorded.

On another date, a staff observed resident exhibiting responsive behaviours towards another resident. A staff documented that the physician ordered one-to-one supervision and to initiate DOS for 5 days. A DOS was initiated, all night shifts and two day shifts were not documented. Step one and three of the form were also incomplete.

Another DOS was initiated. There was no documentation for one night shift and step three. The DOS was continued for another five days and five out fifteen shifts and step three were incomplete.

B) A staff stated they were called to an incident involving another resident, who had allegedly pushed another resident causing them to fall which resulted in an injury.

Following the incident, a staff documented that a DOS was in progress due to resident's responsive behaviour. There was no DOS form found for that period, in the resident's physical file or in their archived record.

Another DOS was initiated and there was no documentation on an evening and a night shift. The DOS was extended and on that day the night shift, the entire next day, the days and evenings of three dates were incomplete. One of the night shift's responsive behaviours were documented in the initials' column excluding the context and was not initialized by the writer. The initials column had an asterix indicating that this was a mandatory field to document.

Another DOS form was initiated, the evening shift as well as two day shifts, including step one and three were also left blank.

Another DOS form was initiated. There were only four shifts out of 15 documented during this period of assessment and observation.

Another DOS form was initiated. There were five shifts documented out of 15.

A staff stated that the DOS related to the missing shifts and, the analysis should have been completed.

Sources:
Residents related health records, including progress notes, Behavioural Supports Ontario (BSO) Dementia Observation System (DOS).
Interviews with the staff members #102, 115, #118, #120, #122 and #127.
Long Term Care Homes, City of Ottawa, Resident Care, Responsive Behaviours: Assessment and Management P&P No:335.13, last revised September 2019. [s. 53. (4) (c)]

Issued on this 28th day of April, 2022

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

Original report signed by the inspector.