Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 11, 2023

Inspection Number: 2023-1537-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: City of Ottawa

Long Term Care Home and City: Centre d'Accueil Champlain, Vanier

Lead Inspector	**Inspector Digital Signature**
Linda Harkins (126)	Linda Harkins Digitally signed by Linda Harkins Date: 2023.05.16 10:29:12 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 25, 26, 27, 28, 2023 and May 1, 2, 3, 4, 2023
The inspection occurred offsite on the following date(s): April 26, 2023 and May 1, 9, 2023

The following intake(s) were inspected:

- Intake: #00001088 - [CI: M511-000030-22], Intake: #00001150 - [CI: M511-000024-22] and Intake: #00014404 – [M511-000040-22] related to falls.
- Intake: #00002919 - [CI: M511-000016-22] related to resident to resident sexual abuse.
- Intake: #00003650 -[CI: M511-000015-22], Intake: #00004665 - [CI: M511-000014-22] and Intake: #00005395 – [CI: M511-000012-22] related to resident to resident physical abuse.
- Intake: #00017425 – Complaint: Allegation of neglect

The following intakes were completed in this inspection: Intake #0006291, [CI #M511-0000022-22], Intake #0011680, [CI #M511-0000036-22], Intake #0015748, [CI #M511-0000043-22] and Intake #0021387, [CI #M511-0000007-23] were related to falls.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care: Safety Risk

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.

The licensee has failed to comply with the requirements to the plan of care which should include safety risk such as Personal Assistance Service Device (PASD) for a resident.

Rational and Summary

A resident had an unwitnessed fall resulting with an injury. A Personal Support Worker (PSW) indicated they removed the lap belt to initiate the care, then turned around and found the resident on the floor. The PSW indicated that the resident was to have a lap belt on for positioning while sitting in the chair.

The resident health care record was reviewed, and it was noted that the safety risks assessment related to the application of PASD for a lap belt and titling the chair was only documented on the "Formulaire de consentement" obtained by the Registered Nurse (RN). The safety risk for the application of the PASD for the lap belt and tilting the chair was not documented in the care plan nor in the kardex. Furthermore, the two PASD monitoring sheets were both labelled "tilting chair" and there was none for the lap belt.

The PSW failed to comply with the resident care plan requirement related to safety risk, by removing the lap belt of the resident which resulted in a fall with an injury.

Sources: resident health care records and interviews [126]

WRITTEN NOTIFICATION: Required Program: Fall Prevention

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the home's Fall Prevention Program, more specifically with the "Lifting and Transferring of the resident" policy and procedure.

In accordance with O. Reg. 246/22 s. 11. (1) (b) the licensee is required to ensure that the Fall Prevention Programs policies and procedures are complied.

Rational & Summary

A resident had an unwitnessed fall and the Personal Support Worker (PSW) indicated they mobilized the resident post fall to sit on the toilet, without the assessment of the registered staff. The resident health care record was reviewed and it was documented in the progress note by the Registered Nurse (RN) that the PSW assisted the resident to sit on the toilet and the assessment was initiated while they were sitting on the toilet.

The PSW did not comply with the home's "Lifting and Transferring of the resident" policy and procedure, which required to have a registered staff assessing the resident post fall to determine the type of transfer required.

Source; Health care record, policies and procedures and staff interviews.[126]

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