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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 2, 2023

Inspection Number: 2023-1537-0002

Inspection Type:
Critical Incident System

Licensee: City of Ottawa

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

Lead Inspector	**Inspector Digital Signature**
Kelly Boisclair-Buffam (000724)	Kelly Boisclair-Buffam Digitally signed by Kelly Boisclair-Buffam Date: 2023.08.03 10:52:48 -04'00'

Additional Inspector(s)
Manon Nighbor (755)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24, 25, 26, 27, 28, 31, 2023

The following intake(s) were inspected:
· Intake: #00021229 - Critical Incident (CI) #M511-000004-23 related to an incident that causes an injury to a resident for which the resident is taken to hospital
· Intake: #00085044 - CI #M511-000010-23 related to a complaint regarding resident's nutritional needs and alleged staff to resident verbal abuse.
· Intake: #00087891 - CI #M511-000016-23 related to a missing resident.
· Intake: #00089792 - CI #M511-000019-23 related to an alleged staff to resident verbal abuse.
· Intake: #00090506 - CI #M511-000020-23 related to resident-to-resident abuse.
· Intake: #00092115 - CI#M511-000023-23 related to a fall with injury resulting in a significant change to a resident.

The following intake was completed in this inspection:
Intake: #00088584 - CI #M511-000018-23 related to a fall with injury resulting in a significant change to a resident.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe storage of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that, drugs are stored in a medication cart, that is secure and locked.

A medication cart was left unattended and unlocked on a resident home area. No other persons were noted in it's vicinity.
When the Registered Practical Nurse (RPN) arrived to the cart , they stated they were assisting a resident.

As such, leaving the medication cart unlocked and unattended, paused a risk for residents to have access to all medication.

Sources: Inspector's observation and RPN
[755]

WRITTEN NOTIFICATION: Residents' drug regimes.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 146 (a)

The licensee has failed to ensure that, when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A resident was injured due to a fall.
The resident's treatment included the administration of a controlled substance as needed to manage their pain. Staff members confirmed that the documentation of the medication effectiveness, should be documented in the documentation administration medication (DAM) progress notes.
The resident's visitor confirmed that staff verified the medication's effectiveness.

As per the Electronic Medication Administration Record (EMAR), the controlled substance was administered to the resident for pain control and the effectiveness of the medication was not documented.

As such, the documentation of the effectiveness of the controlled substance was not documented.

Sources: Progress notes DAM, EMAR, nursing report, interviews with staff members.
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