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: December 14, 2023
Inspection Number: 2023-1537-0004
Inspection Type: Complaint Critical Incident
Licensee: City of Ottawa
Long Term Care Home and City: Centre d'Accueil Champlain, Vanier

Lead Inspector	**Inspector Digital Signature**
Joelle Taillefer (211)	Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.12.28 11:18:12 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 28, 29, 30, 2023 and December 1, 4, 5, 2023.

The following intake(s) were inspected:

-Complaint:

- Intake: #00096365 – related to resident care and support services and medication management.

-Critical Incident Report:

- Intake: #00098424 – related to allegation of physical abuse from resident to resident and skin and wound care.
- Intake: #00101326 - related to an incident where a resident sustained an injury and skin and wound care.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary:
On a date in 2023, the physician ordered to obtain an identified specimen without using an identified collection device.

A Registered Nursing Staff stated that a staff member tried multiple times to obtain the specimen, and they were unsuccessful. One day after the physician order, the Registered Nursing Staff requested a different identified collection device, but they were unavailable and asked a staff member to order some.

The Manager of Personal Care stated that the identified staff member indicated that the identified collection devices were ordered several days after they were requested by the Registered Nursing Staff, and they received the identified collection devices several days later. However, the Registered Nursing Staff were not informed until several days later, that the collection devices were available.

As the resident's identified collection device was ordered on a date in 2023, and the Registered Nursing Staff was not informed until many days later, that the identified collection devices were available in the home, there was a potential risk that the resident suffered from a specific illness during that period of time.

Sources: Resident's health care records and interviews with a Registered Nursing Staff and the Manager of Personal Care.
[211]

WRITTEN NOTIFICATION: Security of drug supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply that they are stored and kept locked, when not in use.

Rationale and Summary:
On an identified date in 2023, Inspector #211 observed multiple medication tablets left in a cup on the table beside a resident's meal tray while the resident was having their meal alone in their room.

The resident stated it was the regular practice to leave the medications at the bedside as they were taken after meals.

A Registered Nursing Staff confirmed that medication should not be left at the resident's bedside.

As the steps were not taken to ensure the security of the drug supply was stored and kept locked, when not in use, there was a potential risk that the resident's medications would not have been administered and that other residents could have had access to these medications.

Sources: Resident's health care records and interviews with a Registered Nursing Staff and a resident.
[211]

COMPLIANCE ORDER CO #001 Behaviours and Altercations

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60 (a) procedures and interventions are developed and implemented to assist

residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Develop and implement interventions to minimize the risk of altercations and potential harmful interactions between the identified resident and other residents.
2. Ensure that staff are available for 1:1 supervision when required to monitor the resident's responsive behaviours.
3. Review and revise the resident's plan of care related to resident's responsive behaviour interventions based on the interventions implemented in step 1.
4. A written record must be kept of everything required under (1), (2), and (3), until the Ministry of Long-Term Care has determined the licensee has complied with this order.

Grounds

The licensee has failed to ensure that interventions were developed and implemented to minimize the risk of altercations and potentially harmful interactions between residents.

Rationale and Summary:

An identified resident's written plan of care dated on a date in 2023, indicated that the resident was exhibiting a specific responsive behaviour on the unit and into another resident's room.

Several weeks later, the identified resident's plan of care, indicated that the resident was exhibiting other multiple identified responsive behaviours during personal care

and there was an altercation incident interaction with another resident.

The identified resident's progress notes within a period of three months indicated that the resident had different type of responsive behaviours. During that period, staff members documented several entries related to the resident's responsive behaviours, which half of them were related to altercations and potential harmful interactions between the resident and different residents. One of the altercations between the resident and another resident resulted in a harmful interaction.

Review of the resident's health care records for the period of 3 months in 2023, indicated that the resident's responsive behaviours were followed by the attending physician and another identified physician. A tool screening was completed twice during the above period to assess the resident's responsive behaviours.

A staff member stated that the resident had an identified responsive behaviour and other types that were unpredictable. The resident's responsive behaviours were exhibited towards staff members during care and towards other residents when aggravated. They were unable to closely monitor the resident's responsive behaviours at all times as they were busy taking care of other residents on the unit.

The Manager of Personal Care stated that the resident was closely supervised by staff members when the resident was around other residents. However, their practice was to put into place a 1:1 staff supervision when a resident exhibited identified responsive behaviours towards other residents.

As the resident was exhibiting an identified responsive behaviour and could unpredictably exhibit another specific responsive behaviour towards other residents, there was a risk that further altercations and potentially harmful interactions could occur between and among residents.

Sources: Residents' health care records and interviews with a Staff member and the Manager of Personal Care.
[211]

This order must be complied with by January 19, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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