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: June 3, 2024	
Inspection Number: 2024-1537-0002	
Inspection Type: Complaint Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Centre d'Accueil Champlain, Vanier	
Lead Inspector Julienne NgoNloga (502)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7, 8, 9, 10, 14, 15, 2024

The following intake(s) were inspected:
Complaint

- Intake: #00112365 - related to resident's transfer to another Long-Term Care home

Critical Incident System Report

- Intake: #00112750 (M511-000008-24) related to a missing resident.
- Intake: #00113533 (M511-000009-24) related to allegation of staff to resident abuse.
- Intake: #00114308 (M511-000010-24) related to allegation abuse and neglect.

- Intake: #00114585 (M511-000011-24) related to allegation of neglect and medication administration.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance of abuse

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (d)
Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(d) shall contain an explanation of the duty under section 28 to make mandatory reports;

The licensee has failed to comply with the home's policy to promote zero tolerance of abuse and neglect of residents.

In accordance with O. Reg 246 / 22 s. 11 (1) (b), the licensee shall ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents contain an explanation of the duty under section 28 to make mandatory reports and is complied with.

Specifically, staff did not report immediately to the charge nurse upon becoming aware of the allegation of staff to resident abuse.

Rationale and Summary
Review of the home's policy titled Maltraitance et negligence, #750.65 revised on July 2023, indicated that any allegation should be reported immediately to the Charge Nurse who will immediately report that to the Administrator or designate.

Review of Formulaire de Plainte showed that in April 2024, the resident reported to the staff member that another staff member allegedly abuse them by making specified remarks.

A staff member indicated that they left the completed Formulaire de plainte for the Director of Care (DOC) to follow up.

The allegation of abuse was reported to the Director couple of days after staff of the home became aware of the incident.

By not reporting immediately the alleged incident to the charge nurse, steps were not taken to ensure the resident safety.

Sources: CIS, Formulaire de plainte. Interview with a staff member.
[502]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 1. ii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
ii. equipped with a door access control system that is kept on at all times, and

The licensee has failed to ensure that residents did not have access to doors leading to stairways at the East end of the hallway, and that the door was equipped with a door access control system that was kept on at all times.

Rationale and Summary
A resident's progress notes indicated that a day in June 2023, the resident exited a unit through the East side stairwell door, which was not locked.

The progress notes indicated that the resident was known to exhibit identified behaviours since admission. A day in April 2024, a police officer informed the home that the resident was found walking a few blocks from the Long-Term Care home. The camera footage confirmed the date and time that the resident eloped for three hours through the East side stairwell door. The door electronic lock malfunctioned at the time the resident exited the unit.

In an interview, two staff members stated that on the day of the incident, they

assumed the resident was wandering in other residents' room or within the unit, and they did not bring the resident's absence to anyone's attention.

By not maintaining the East side stairwell door access system that is kept on at all times, placed the resident at safety risk when they wandered outside the secured unit for hours.

Sources: CIS, resident progress notes and plan of care. Interviews with staff members.
[502]

COMPLIANCE ORDER CO #001 Duty to protect

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) Provide training on emotional abuse to ensure understanding by all staff who provide care on a resident's care area and the Administrative Assistance identified in the report.
b) Keep a written record of this training. The record shall include:

- staff who provided the training,

- staff who participated in the training,
- the date of when the training took place and,
- a copy of the training material.

Grounds

The licensee has failed to protect a resident from abuse by a staff.

2. (1) (a) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, any threatening, insulting, intimidating, or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Rationale and Summary

A resident reported that a day in April 2024, a staff member made specified remarks. The staff member continued to provide care to the resident for several days after the incident was reported to the staff of the home.

In an interview, the resident reported that the staff member made specified remarks. The resident stated that the remark made them feel worthless that they had contemplated self-harm. The staff member stated that the resident misunderstood their remarks.

As such, the remarks made by the staff member impacted the resident mental well-being, the resident required additional supports in response to the incident, and the remark placed them at risk of harm.

Sources: CIS, Interview with the resident and staff member.

[502]

This order must be complied with by

August 31, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.