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
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Original Public Report

Report Issue Date: November 4, 2024
Inspection Number: 2024-1008-0004
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Champlain Long Term Care Residence, L'orignal

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30, 31, 2024 and November 1, 4, 2024.

The following intake(s) were inspected:

- Intakes: #00120626 and #00122150 regarding resident falls that resulted in injuries.
- Intake: #00125624 and #00130492 regarding resident-to-resident physical abuse from altercations causing injuries.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a PSW staff used a safe transferring device and technique when assisting a resident whereby the resident fell and sustained an injury.

Sources: Observations of this resident and their mobility device, interviews with the resident, an RN and the IPAC Manager and review of the resident's health care records.