Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2014	2014_286547_0003	O-001224-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

CARLINGVIEW MANOR
2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 20-21, 2014, and February 14, 2014

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the Director of Care , the Resident Services Coordinator, the Environmental Services Manager, a Clinical Nurse Manager, the Geriatric Outreach Psychiatry nurse from Royal Ottawa Hospital, an Environmental Services-Personal Department staff, the Staffing Coordinator (Nursing), a Dietary Aide, several Registered Practical Nurses and Personal Support Workers, Family and Residents.

During the course of the inspection, the inspector(s) reviewed the informant's letter of complaint, the home's copy of their response from the letter of complaint, health care records for Resident #001, the home's policy for Management of Concerns/Complaints/Compliments (LP-B-10), policy for Lost Personal Items (ESP-A-85), observations of Staff/Resident and Resident/Resident interactions for Resident #001, and observed care of Resident #001 in the home. Reviewed video files provided by the Informant.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O.2007 c.8, s. 6 (7) in that the care set out in the plan of care is not provided to Resident #001 as specified in the plan.

-The plan of care for Resident #001 indicates to provide care by two staff at all times due to behaviours.

-A sign placed above Resident #001's bed indicates the resident requires two person transfer is in place.

-On a specified date in January, 2014 it was observed that Resident #001 was transferred to bed from wheelchair by one staff member.

Files from a video camera in Resident #001's room on two specified dates in January, 2014 provided by the informant showing care being provided to Resident #001 indicated the following:
- A video file from a specified date in January, 2014 showing one staff member assisting Resident #001 with care. The person filming pointed to the sign above the resident's bed and said that "the resident required 2 person assistance". The one staff member proceeded to assist the resident to sit up alone. The resident had facial grimace, with verbal grunts indicating difficulty with transfer from lying to sitting. Resident #001 began breathing with an audible wheeze after this transfer.

-This same video file showed one staff member assisting Resident #001 to transfer back to bed from wheelchair. The staff member sat Resident #001 on the bed in an uncontrolled manner resulting in the resident falling back with the resident's head coming close to the side rail on the far side of the bed. Staff member then transferred the resident's feet and knees into bed. Resident #001 continued to have audible respiratory wheeze and facial grimace after this transfer.

- Another video file from a specified date in January, 2014 showing one staff member assisted the resident to transfer from wheelchair to bed.

As such, Resident #001's care set out in the plan of care to have two staff members at all times during care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance regarding the care set out in the plan of care for Resident #001 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg s 36 by not using safe transferring and positioning techniques when assisting Resident #001 with care.

Files from a video camera in Resident #001's room on specified dates in January, 2014 provided from the informant showing care being provided by a staff member to Resident #001, indicated the following:

- A video file from a specified date in January, 2014 showing a staff member placing hospital gown on Resident #001 while Resident #001 was lying on top of the comforter of the bed. Staff member then proceeded to remove the comforter from underneath the resident. The resident was becoming very frustrated and uncomfortable with facial grimace while being asked to roll back and forth. The one staff member proceeded to assist the resident to sit up, and the resident had facial grimace, with verbal grunts indicating difficulty with transfer. The resident fell back in the bed on the first attempt. The staff member then took the resident's right arm and placed her left hand behind the resident's neck to pull the resident to a seated position. The resident was visibly uncomfortable during this transfer. The one staff member transferred the resident to the wheelchair by holding the resident under one arm, and the back of the resident's brief. The resident's affected arm was not supported during this transfer. The resident was transferred quickly, and was not seated in a controlled method. The resident then let out a loud grunt upon sitting.

This same staff member transferred Resident #001 from wheelchair back to bed. This one staff member assisted the resident without supporting Resident #001's affected side during the transfer. The staff member sat Resident #001 on the bed in an uncontrolled manner resulting in the resident falling back with the resident's head coming close to the side rail on the far side of the bed. Staff member then transferred the resident's feet and knees into bed. Resident #001 has an audible respiratory wheeze and facial grimace after this transfer.

- Another video file from a specified date in January, 2014 showing one staff member assisted resident #001 to bed from wheelchair assisting from the Resident's non affected side leaving the affected side unsupported. The resident did most of the transfer alone. Staff member was at a distance from the resident during the transfer and was no longer within reach at the end of the transfer, to support the resident once the resident was seated in the bed.

As such, Resident #001 does not have safe transferring and positioning techniques when assisting the resident for care. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance regarding safe transferring and positioning techniques provided to Resident #001 when assisting for care, to be implemented voluntarily.

Issued on this 21st day of February, 2014

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs