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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2015	2015_225126_0013	O-001789-15	Resident Quality Inspection

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

LINDA HARKINS (126), KATHLEEN SMID (161), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592), SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 7,8,9,10,13,14,15 and 16, 2015

During this inspection the following inspections were conducted: Logs # O-001793-15, O-001774-15, O-001723-15, O-001712-15, O-001565-15, O-001562-15, O-001458-14, O-000891-14, O-001850-15, O-001911-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Activity Manager, the Environmental Manager, several Clinical Managers, the Infection Control Nurse/Staff Development Educator, several Registered Nurses, several Registered Practical Nurses, several Personal Support workers, the President of the Resident Council, several residents and several family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.reg 79/10 s. 15 (1) (a)in that the licensee did not ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails are addressed.

On April 6 and 7, 2015, Inspector #592 observed in rooms # 620, #621 and #729, quarter rails in disrepair and not well secured to the bed frames causing potential entrapment zones and safety risks for residents.

On the same days, in room #729 inspector #592 observed a quarter bed rail bending outward from the mattress, leaving a gap of 4 inches between the mattress and the rail. In Room # 619 the bed was also observed with an 8 inch gap between the foot board and the mattress. The mattress did not fit the bed properly and slid when slight pressure was applied.

On April 10, 2015, during an interview with PSW Staff #100, he told inspector #592 that the PSWs are to write any disrepairs or safety concerns in the communication pad located on each floor at the nurse's desk. He further indicated that if the concern is an emergency, the PSWs are to report it to the nurse to contact the maintenance department to get the problem fixed right away. In addition he told inspector #592, that maintenance staff is assign to each unit each morning to do follow-up on any disrepair.

On April 10, 2015, during an interview with the Environmental Manager, he told inspector #592 that the maintenance was responsible for assessing the bed systems and

correcting disrepair. He told inspector #592 that the home had bought new beds and mattresses and that full bed rails were removed and replaced by quarter rails. He indicated that a monthly assessment of side rails and bed systems was completed on each floor. He further indicated that maintenance staff is responsible to immediately report any side rails in disrepair and he deals with it directly.

Following the interview, inspector #592 and the Environmental Manager observed the mattress in room # 619. He told inspector #592 and the resident who was present, that the mattress was an old one and that this mattress should have been and will be replaced. He also told the resident that in the meantime, a gap filler would be required due to the space between the foot board and the mattress and it would be put in place.

Side rails in room #620, #621, #729 (2 beds) were also shown to the Environmental Manager who indicated that these rails were not maintained in a safe condition and were not in a good state of repair, so they would be fixed immediately.

Later that day, the Environmental Manager, provided the Inspector with the March 13, 2015 side rail assessment for rooms #620, #621, #729. No safety issues were reported and as per the schedule the next assessment was to be conducted in September 2015. The Environmental Manager told inspector #592 that he will increase the frequency of the side rail assessments and do a follow-up with his department to ensure that the side rails are maintained in a safe condition. [s. 15. (1) (a)]

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 to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and other safety issues related to the use of bed rails are addressed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, is compiled with.

On a specific day in March 2015 , it is documented in the progress notes that Resident #06 reported to Registered Practical Nurse (RPN) S# 101 that a resident had pushed her/his wheelchair into the room and had tried to touch her/him inappropriately. Resident #06 was whispering her/his concerns to S# 101 and was pointing to Resident #15. Resident #06 also indicated that he/she could not do anything and was very scared of Resident #15.

On April 10, 2015, Inspector #126 spoke to S# 101 who indicated that she told Resident #06 to call for help if anyone touch her/him inappropriately. S# 101 indicated that following the reporting of the incident, she interviewed Resident #15 who did not recall the incident and staff reported that they did not observed any inappropriate behaviors from Resident #15 to the Clinical Manager.

On April 10, 2015, Inspector # 126 spoke to Clinical Manager S# 102 who indicated that she found out about the above incident by reviewing the morning report. She indicated that she came to the unit that specific morning of March 2015 and interviewed Resident #06 and Resident #15, neither Residents could not recall the incident. S #102 indicated that no further action was taken as both Residents did not remember the incident.

The home's policy to promote zero tolerance of abuse and neglect of residents, LP-C-20-ON, Revised September 2014, indicates the following under mandatory internal reporting: "Any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home, or if unavailable to the most senior supervisor on shift at the time. The person reporting the

suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately. "

On April 10, 2015, Inspector #126 spoke with the home's DOC who indicated that she was not aware or notified of the alleged incident between Resident #06 and Resident #15. The DOC indicated that the policy requires that staff with reasonable grounds to suspect abuse are to immediately report to the ED or herself. The home's DOC acknowledged that the nursing staff did not follow the policy related to internal reporting, in this instance. [s. 20. (1)] [s. 20. (1)]

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 to ensure any suspected, alleged or witnessed abuse is reported as per policy,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply in that the residents of the home shall have his or her personal items labelled within 48 hours of admission.

On the initial tour of the home on April 7, 2015, Inspector # 592 observed in the spa room on the second floor, one nail clipper and 2 hair combs with hair that were unlabelled.

On April 7, 2015, Inspector #161 observed in the shower room on the third floor, 3 rolls on deodorant and 1 comb and in the tub room 2 rolls on deodorant, 1 com and 1 nail clipper that were unlabelled.

On April 8, 2015, Inspector # 126 observed on the fourth floor, 3+1 toothbrushes on the bathroom counter of two different bedrooms shared by 4 residents were unlabelled.All residents in those bedrooms have been living in the home more than 48 hours. [s. 37. (1)]

Issued on this 22nd day of May, 2015

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

Original report signed by the inspector.