Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 1, 2011	2011_117_2420_01Feb133408	Critical Incident Log # O-002873

Licensee/Titulaire

Revera Long Term Care Inc.
55 Standish Court, 8th floor
Mississauga ON
L5R 4B2
Fax: (289).360.1201

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

Carlingview Manor
2330 Carling Avenue
Ottawa, ON
K2B 7H1
Fax: (613) 820-9774

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

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

Ontario

Ministry Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

The purpose of this inspection was to conduct a critical incident inspection related to a resident being physically abusive towards two other residents.

During the course of the inspection, the inspector spoke with the home's Executive Officer, to the home's Director of Care, to two Registered Practical Nurses, to two Personal Support Workers and to a resident.

During the course of the inspection, the inspector reviewed a resident's health care record, a resident care unit's 24- hour shift reports and observed a resident on a resident are unit's hallways and dining room.

The following Inspection Protocol was used during this inspection:

- Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

4 WN
2 VPC
2 CO

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the O. Reg. 79/10, s 53 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible;

Findings:

- A resident with aggressive behaviours is an active wanderer. On December 2, 2010 the resident eloped from the home's 2nd floor secure unit. He/she pushed through a locked stairwell door when the door was being opened by a staff member coming on to the unit. The resident went down to the home's lounge area and then to the fenced patio area. He/she tried to climb over the patio fence. The Ottawa Police were called to assist with the resident's behaviour and get him/her back to the 2nd floor secure unit.

- Two interviewed Personal Support Workers and a Registered Practical Nurse report that the resident demonstrates various behavioural changes that precede increased exit seeking behaviours on evenings. These behavioural changes include increased aggression towards other residents, increased impulsivity, packing clothes, carrying bags, moving furniture in and out of his/her room.

- An interviewed Registered Practical Nurse states that the resident's exit seeking behaviours escalate in the evenings. He/ she states that one of the interventions used to redirect the resident is having him/her watch hockey games.

- It was noted on February 1, 2011 that the resident's health care record and plan of care do not identify behavioural triggers related to the resident's wandering and exit seeking behaviours. The interviewed nursing staff state that they do not know if all nursing staff are aware of the resident's behavioural triggers and nursing interventions used to minimize or respond to these behaviours.

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Additional Required Actions:

VPC #1 - 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 need to ensure that resident specific behavioural triggers are identified; and that written strategies and approaches to care are developed to meet the needs of the identified resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

c) clear directions to staff and others who provide direct care to the resident.

(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

Findings:

- A resident with aggressive behaviours is an active wanderer. On December 2, 2010 the resident eloped from the home's 2nd floor secure unit. He/she pushed through a locked stairwell door when the door was being opened by a staff member coming on to the unit. The resident went down to the home's lounge area and then to the fenced patio area. He/she tried to climb over the patio fence. The Ottawa Police were called to assist with the resident's behaviour and get him/her back to the 2nd floor secure unit.

- Two interviewed Personal Support Workers and a Registered Practical Nurse report that the resident demonstrates various behavioural changes that precede increased exit seeking behaviours on evenings. These behavioural changes include increased aggression towards other residents, increased impulsivity, packing clothes, carrying bags, moving furniture in and out of his/her room.

- An interviewed Registered Practical Nurse states that the resident's exit seeking behaviours escalate in the evenings. He/ she states that one of the interventions used to redirect the resident is having him/her watch hockey games.

- It was observed on February 1, 2011 that the resident has a wanderguard bracelet on his/her left wrist. Interviewed nursing staff stated that they were not aware that the resident had a wanderguard bracelet on his/her left wrist.

- It was noted on February 1, 2011 that the resident's health care record and plan of care do not identify behavioural triggers related to the resident's wandering and exit seeking behaviours. The interviewed nursing staff state that they do not know if all nursing staff are aware of the resident's behavioural

Inspector ID #:	# 117

Additional Required Actions:

VPC #2 - 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 need to ensure that there is a written plan of care for the identified resident that sets out clear directions to staff and others who provide direct care to the resident ensure that the identified resident is reassessed and the plan of care reviewed when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily

WN #3: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s (24) (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

(2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Findings:

- The home's Administrator contacted MOHLTC Duty Inspector on November 30 2010 to advise MOH that the Administrator had not immediately reported an incident of resident to resident abuse that occurred on November 23, 2010. The CIS report regarding the incident of resident to resident abuse was received by the MOH on December 1, 2010.

- November 23 2010, a resident was physically abusive towards two other residents and one Personal Support Worker. The first resident was slapped on the face by the identified resident and sustained a bruise to the right side of his/her face. The second resident was slapped on the face by the identified resident and had blood on his/her nostrils and hands. The second resident also sustained a small skin tear to his/her chin. A Personal Support Worker was pushed from the back, up against the wall by the identified resident who then twisted his/her left hand. The Personal Support Worker sustained abrasions to his/her right hand.

Compliance Order #001 was faxed to the licensee – See Order Report

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WN #4: The Licensee has failed to comply with O.Reg. 79/10, s 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

- The home's Administrator did not report an incident of resident to resident abuse that occurred on November 23, 2010 to the Ottawa Police Services.

- November 23 2010 a resident was physically abusive towards two other residents and one Personal Support Worker. The first resident was slapped on the face by the identified resident and sustained a bruise to the right side of his/her face. The second resident was slapped on the face by the identified resident and had blood on his/her nostrils and hands. The second resident also sustained a small skin tear to his/her chin. A Personal Support Worker was pushed from the back, up against the wall by the identified resident who then twisted his/her left hand. The Personal Support Worker sustained abrasions to his/her right hand.

Compliance Order #002 was faxed to the licensee – See Order Report

Inspector ID #:	#117

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: Date:	**Date of Report:** (if different from date(s) of inspection). February 9, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Lyne Duchesne	**Inspector ID #**	117
Log #:	O-002873		
Inspection Report #:	2011_117_2420_01Feb133408		
Type of Inspection:	Critical Incident		
Date of Inspection:	February 1, 2011		
Licensee:	Revera Long Term Care Inc. 55 Standish Court, 8th floor Mississauga ON L5R 4B2 Fax: (289).360.1201		
LTC Home:	Carlingview Manor 2330 Carling Avenue Ottawa, ON K2B 7H1 Fax: (613) 820-9774		
Name of Administrator:	Cathy Drouin		

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s (24) (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

(2) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that a person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by February 18, 2011 via fax # (613) 569-9670

Grounds:

- The home's Administrator contacted MOHLTC Duty Inspector on November 30 2010 to advise MOH that the Administrator had not immediately reported an incident of resident to resident abuse that occurred on November 23, 2010. The CIS report regarding the incident of resident to resident abuse was received by the MOH on December 1, 2010.

- November 23 2010 a resident was physically abusive towards two other residents and one Personal Support Worker. The first resident was slapped on the face by the identified resident and sustained a bruise to the right side of his/her face. The second resident was slapped on the face by the identified resident and had blood on his/her nostrils and hands. The second resident also sustained a small skin tear to his/her chin. A Personal Support Worker was pushed from the back, up against the wall by the identified resident who then twisted his/her left hand. The Personal Support Worker sustained abrasions to his/her right hand.

This order must be complied with by:	February 18, 2011		
Order #:	002	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with O.Reg. 79/10, s 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by February 18, 2011 via fax # (613) 569-9670

Grounds:

- The home's Administrator did not report an incident of resident to resident abuse that occurred on November 23, 2010 to the Ottawa Police Services.

- November 23 2010 a resident was physically abusive towards two other residents and one Personal Support Worker. The first resident was slapped on the face by the identified resident and sustained a bruise to the right side of his/her face. The second resident was slapped on the face by the identified resident and had blood on his/her nostrils and hands. The second resident also sustained a small skin tear to his/her chin. A Personal Support Worker was pushed from the back, up against the wall by the identified resident who then twisted his/her left hand. The Personal Support Worker sustained abrasions to his/her right hand.

This order must be complied with by:	February 18, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order 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 or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

9th Floor
Toronto, ON
M5S 2T5

55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

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

Issued on this 9th day of February, 2011.	
Signature of Inspector:	Lyne Duchesne
Name of Inspector:	Lyne Duchesne
Service Area Office:	Ottawa