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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 17, 2018 | 2018_559142_0006 | 017436-18, 017955-18 | Complaint |

### Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

### 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

JANET MCPARLAND (142)

### 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): July 26, 27, 30, 31, August 1, 9, 10, 13 and 14, 2018**

**The following intakes were completed during the complaint inspection:**
**-Log #017436-18-complaint related to resident care**
**-Log #017955-18-critical incident report (CIR #2420-000054-18) related to an unexpected death**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Associate Director of Care (ADOC), Physiotherapist (PT), Director of Care (DOC), Assistant Executive Director and Executive Director.**
**During the course of the inspection, the inspector, reviewed a resident health record, licensee's investigation documents related to an unexpected death and applicable policies. In addition, inspector observed provision of care related to the use of mechanical lifts.**

**The following Inspection Protocols were used during this inspection:**
**Hospitalization and Change in Condition**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that provision of care set out in the plan of care was documented.

Resident #001 care flow sheets were reviewed for an identified period of time in 2018. The care flow sheets identified provision of care required for resident #001 and included care related to activities of daily living such as bathing/hygiene, bed mobility, dressing, locomotion, toilet use and transferring.
It was noted that the provision of care related to activities of daily living was not documented on the following dates:
-Day shifts (0700-1500 hours) for two identified dates in June 2018
-Evening shifts (1500- 2300 hours) for eight identified dates in June and July 2018

In reviewing the staffing schedule for an identified resident home area, for a specified period in June 2018, it was determined that PSW staff from an agency worked on specified dates in June 2018.

In an interview with RPN #101 and Associate Director of Care #128, both indicated that when agency PSW staff provide care to residents they do not have the ability to document the provision of care in the resident's electronic record (referred to as point of care). [s. 6. (9) 1.]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #001 was admitted to the home on a specified date.

As per resident #001's plan of care for an identified date, the resident required support for transfers due to disease process (dementia), decreased strength/balance, and identified medical diagnosis. Interventions in place for assistance with transfers included the use of an identified mechanical lift.

The Licensee has in place a Safety in Ambulating lifting and transferring program (SALT - policy #HS16-0-20 revised January 2014). The policy indicates that each resident is to be assessed on admission and at a minimum of quarterly thereafter, to identify and document their status regarding weight bearing and mobility to determine needs related to transferring, lifting, repositioning and other resident maneuvering activities as appropriate. The policy further identifies that where a resident's condition remains relatively stable, this review will affirm the present approaches documented on the care plan. The assessment is documented on the SALT e-assessment tool.

In reviewing resident #001's health record, it was noted that the most recent SALT e-assessment tool was completed on a specified date. This assessment indicated that resident #001 required the use of a specific mechanical lift.

In an interview with RPN #101, they indicated that a SALT assessment was completed on a specified date when staff reported the resident had a change in condition. RPN #101 indicated that they observed staff transfer resident to determine resident's needs related to transferring and it was determined that resident was able to continue to require the use of the identified mechanical lift. RPN#101 further indicated that they did not document the assessment on the SALT e-assessment tool.

Inspector #142 reviewed resident #001's health record with Associate Director of Care #128, who confirmed that the most recent documented SALT e-assessment was completed on a specified date.

The licensee failed to ensure that quarterly reassessments were documented using the licensee's SALT tool for resident #001 to determine the residents' status regarding weight bearing and mobility to determine resident's needs related to transferring, lifting and repositioning. [s. 30. (2)]

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**Issued on this 18th day of September, 2018**

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

**Original report signed by the inspector.**