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 prévue 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 16, 2018	2018_617148_0035	017590-18, 022106-18, 027286-18, 028878-18	Critical Incident System

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 6, 7, 8, 9, 13 and 14, 2018

This inspection included four critical incident reports (CIR): two related to alleged resident to resident abuse (Log 022106-18/ CIR #2420-000061-18 and Log 028878-18/ CIR #2420-000078-18) in addition to two related to an incident that caused an injury to a resident for which the resident was taken to hospital and that results in a significant change in health condition (Log 017590-18/ CIR #2420-000052-18 and Log 027286-18/ CIR #2420-000069-18).

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Assistant Executive Director, Director of Care, Associate Director of Care, Schedule Clerk, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers and residents.

The Inspector reviewed resident health care records, medication management policies and the home's investigation documents, as applicable. In addition the Inspector observed the resident care environment and resident to resident and staff to resident interaction.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #003 was admitted to the home on a specified date. Information available to the licensee prior to admission included a behavior assessment whereby the resident was described as having exit seeking behaviours.

In review of the health care record it was noted that within two weeks after admission, a progress note written by RPN #113, described the resident as exhibiting exit seeking behaviours. During an interview with evening RPN #113, it was reported that resident #003 is known to exit seek daily.

The plan of care was updated to include responsive behaviours approximately three weeks after admission, after an incident of alleged resident to resident abuse. The plan of care as at the time of inspection, did not include the resident's exit seeking behaviours; in this way the plan of care was not based on the resident needs.
(Log 028878-18) [s. 6. (2)]

2. The licensee has failed to 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 the care set out in the plan has not been effective.

The care set out for resident #003 included the provision of a medication as needed. On

a specified date, RPN #113 administered the medication; the effectiveness for which was documented as unknown. The Inspector spoke with RPN #113 who could not recall the state of the resident after the administration and could not confirm that the resident had been reassessed.

The care set out for resident #001 includes the provision of a medication as needed. On a specified date, RPN #114 administered the medication related to the resident exhibiting physical aggression; the effectiveness was documented as not effective as the resident was observed to continue to exhibit responsive behaviours. The Inspector spoke with RPN #114 who could not recall if the resident had been reassessed in relation to the ineffective medication.

Resident #001 and #003 were not reassessed when the care set out in the plan had not been effective.
(Log 022106-18 and 028878-18) [s. 6. (10) (c)]

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 a resident is reassessed and the plan of care reviewed and revised at any other time when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, the licensee is required to ensure that the policy or protocol is complied with.

In accordance with section 114 of O.Regulations 79/10, the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home.

The Inspector was provided with a policy titled LTC- PRN Medications- Administration and Documentation, #CARE 13-010.05, last reviewed March 31, 2018. The policy directs the nurse to document the reason for administration and its effectiveness when administering a PRN medication.

The care set out for resident #003 includes the provision of a medication as needed. On a specified date, the medication administration record indicates that RPN #113 administered the identified medication. In review of the health care record there was no documentation as to the reason for administration of medication. The Inspector spoke with the RPN who could not recall the reason for this administration.
(Log 028878-18) [s. 8. (1) (b)]

Issued on this 16th day of November, 2018

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

Original report signed by the inspector.