Ontario

Ministry of 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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2019	2019_770178_0013	011202-19, 011369-19, 011961-19, 012612-19, 012929-19, 013076-19, 013157-19	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

SUSAN LUI (178), 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): July 8, 9, 10, 11, 12, 16, 17, 18, 19, 2019.

The following Logs were inspected:
011202-19 and 012929-19 regarding alleged resident to resident sexual abuse,
011369-19 regarding alleged resident to resident physical abuse,
011961-19 regarding an unexplained injury,
012612-19, 013076-19, and 013157-19 regarding falls with injuries.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Associate Director of Care (ADOC) #110, ADOC #111, Physician #115, an Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Payroll/Scheduling Clerk.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, an interdisciplinary assessment of behaviour pattern, identified responsive behaviours, any potential behavioural triggers and safety risks.

This non-compliance is related to Log #011202-19.

As described by WN #2, resident #005 and resident #006 were involved in an incident of alleged sexual abuse. During the investigation conducted by ADOC #111, PSW #105 reported that resident #006 had removed the continence product of resident #005, twice before and it was reported that resident #006 was attempting to assist resident #005 with changing of the product. The critical incident report (CIR) submitted by ADOC #111 indicated that long term actions included a review of the plan of care quarterly to assess changing needs and reflect current care requirements. In an interview with ADOC #111, it was described that the plan of care would reflect that there had been alleged sexual abuse and describe the interventions in place to mitigate the risk to co-residents. The plan of care for resident #006 was reviewed and does not contain information related to the alleged sexual abuse or the interventions to mitigate risk. Resident #006 was moved to a different unit soon after the incident. When interviewed by the Inspector, staff on this unit were not aware of the resident's historical sexual behavior or potential risks to co-

residents.

The plan of care for resident #006 was not based, at minimum, on as assessment of the residents behavioral pattern and safety risks. [s. 26. (3) 5 and s. 26. (3) 19]

2. The licensee has failed to ensure that the plan of care for resident #001 was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity and foot conditions.

This non-compliance is related to Log #011961-19.

CIR # 2420-000032-19, which was submitted by the licensee indicated that resident #001 sustained an unexplained injury to an identified body part, resulting in amputation.

Inspector #178 reviewed resident #001's plan of care in place at the time the unexplained injury was identified. Resident #001 has lived in the long-term care home for more than six months, is cognitively well, and has a history of diabetes mellitus and traumatic amputation of two or more digits. The plan of care indicated that resident #001 required assistance with bathing, dressing, hygiene and grooming. The plan of care did not indicate that resident #001 frequently refused assistance with this care and did not include strategies to ensure that resident #001's skin and feet were routinely assessed for injury or skin impairment when the resident refused assistance with bathing or dressing/undressing.

During an interview with Inspector #178, resident #001 indicated that before being admitted to the long-term care home last year, they had specified digits amputated due to infection. Resident #001 further indicated that they recently lost more digits as a result of an injury. Resident #001 could not explain how they sustained the recent injury and indicated they did not feel any pain from the injury until after the surgery to amputate the digits. Resident #001 indicated that they have frequently refused staff's assistance with washing, dressing and transferring from bed to chair. Resident #001 indicated a desire to remain independent with these activities as the reason for refusing staff's assistance.

During interviews, PSW #119, PSW #122, RPN #121 and RPN #126 all indicated to Inspector #178 that resident #001 frequently refused assistance with personal care such as bathing and dressing. RPN #126 indicated to Inspector #178 that resident #001 was admitted to the home with specified wounds and that the resident cannot feel specified

body parts. RPN #126 indicated that there was a routine in place to check the resident's specified body parts for wounds, but it was discontinued once resident #001's wounds were healed.

ADOC #111 indicated the following to Inspector #178:
Resident #001 has impaired feeling in an identified body part and prior to being admitted to the long-term care home had digits amputated due to poor healing. When staff discovered resident #001's recent unexplained injury, the doctor assessed the resident and felt the injury had happened within the previous two weeks. ADOC #111 investigated the incident by interviewing the resident and all the staff who had cared for them in the two weeks prior to discovery of the injury but was unable to determine when or how the injury occurred. The PSW staff is expected to check all residents' skin for any impairment twice daily when they provide assistance with bathing and dressing, and then report any impairment to the registered nursing staff. Because resident #001 routinely refused assistance with bathing and dressing, this made it difficult to determine when the unexplained injury happened. At the time of the recent unexplained injury, resident #001's refusal of care was not identified on the resident's plan of care, and their plan of care did not include a strategy to ensure that resident #001's skin and specified body parts were checked regularly for wounds.

The plan of care for resident #001 was not based on an interdisciplinary assessment of the resident's skin integrity and foot conditions. [s. 26. (3) 15]

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 the plan of care is be based on, at a minimum, interdisciplinary assessment of behaviour pattern, identified responsive behaviours, any potential behavioural triggers, safety risks, and skin condition, including altered skin integrity and foot conditions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that 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 has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, PSW #105 and #106 were conducting resident safety checks. Upon entering the room PSW #105 and #106 found resident #005 to be seated at the edge of the bed. Co-resident #006, who was awake in the next bed, approached resident #005 and shook the resident's hand. PSW #105 noted the behavior as unusual and questioned resident #005. During the conversation, resident #005 said that resident #006 pulled resident #005's pants down and played with it. PSW #105 reported to the Inspector that PSW #105 interpreted this to mean that resident #006 had touched resident #005 in a sexual nature. During the shift, the PSW informed RPN #112 that something had occurred but did not provide details of the incident. It was not until the end of shift that a full report, including a written account by PSW #105, was provided to RPN #112 and subsequently to night charge RN #113. The report and written account were then provided to ADOC #110 and ADOC #111. ADOC #111 reported the incident of alleged sexual abuse to the Director approximately 18 hours after staff had reasonable grounds to suspect sexual abuse of a resident.

In this way, the Director was not informed immediately of an alleged resident abuse. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include: a description of the incident, including the events leading up to the incident; and a description of the individuals involved in the incident including names of staff member present or responding to the incident.

In accordance with section 23 of the Act the licensee shall immediately investigate and take appropriate action in response to every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee.

As described by WN #2, resident #005 and resident #006 were involved in an incident of alleged sexual abuse. The critical incident report submitted by ADOC #111 was reviewed and did not describe the events leading up to the incident including the behaviors of resident #006 to remove the continence product of resident #005. In addition, the report did not include the names of PSW #106 who was present at the incident or staff members RPN #112 and RN #113 who responded to the incident. [s. 104. (1) 1.]

Issued on this 21st day of August, 2019

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

Original report signed by the inspector.