Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 14, 2020	2020_809733_0009	007026-20, 009977-20, 010266-20, 011706-20, 012836-20, 016307-20, 018369-20	Critical Incident System

Licensee/Titulaire de permis

Carlingview Manor Operating 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

MARK MCGILL (733), MEGAN MACPHAIL (551)

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): August 31, September 1,2,3,4,8,9,10,11,14,15,16,17,18,21,2020

Log 007026-20 (CIS: 2420-000020-20) and log 010266-20 (CIS:2420-000022-20) are related to falls.
Log 009977-20 (CIS: 2420-000021-20) and log 012836-20 (CIS: 2420-000026-20) are related to alleged physical abuse.
Log 011706-20 (CIS: 2420-000025-20) and log 018369-20 (CIS: 2420-000034-20) are related to an injury with an unknown cause.
Log 016307-20 (CIS: 2420-000030-20) is related to alleged neglect.
During the course of the inspection, the inspectors made observations related to the provision of care to residents, interviewed staff and management and reviewed health care records.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Resident Services Coordinator, Clinical Managers, Behavioral Supports Ontario, Physiotherapist, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 the person who had reasonable grounds to suspect that abuse of resident #003 by resident #002 was immediately reported to the Director.

Section 2 (1) of the Ontario Regulation 79/10 defines Physical abuse as the use of physical force by a resident that causes physical injury to another resident.

The Director was informed that "Resident A was found on the floor in the hallway due to being pushed by Resident B." According to the CIR, the following day, the resident who had fallen expressed pain, and following an x-ray was sent to hospital where an injury was confirmed.

PSW #110 stated that on the day of the incident, they saw resident #003 enter resident #002's room and immediately proceeded to the room. Before entering, the PSW heard a large thump, and they suspected that resident #002 had shoved resident #003 as the resident was on the floor.

Sources: CIR 2420-000021-20, interview with PSW #110 and other staff, and a review of the health care records for resident #002 and resident #003. [s. 24. (1)]

Issued on this 18th day of November, 2020

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

Original report signed by the inspector.