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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 19, 2013	2013_199161_0005	O-000072-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

KATHLEEN SMID (161)

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): on-site March 4, 5, 6, 7, 8, 2013.

During the course of the inspection, the inspector(s)conducted four Critical Incident Inspections.

During the course of the inspection, the inspector(s) spoke with an identified Resident, Personal Support Workers, Registered Staff members, Clinical Managers, interim Director of Care and the Executive Director.

During the course of the inspection, the inspector(s) observed identified resident, reviewed resident health records and home's Fire Safety Plan and Falls Interventions Risk Management Program.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Hospitalization and Death

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 :

The licensee failed to comply with LTCHA 2007 c.8, s.6 (10)(b) in that the licensee did not ensure that a Resident's plan of care was reviewed and revised when the Resident's care needs change.

Resident # 003 was admitted to Carlingview Manor in April 2012 with dementia.

On a date in February 2013 Resident # 003 was found holding Resident # 005 by the throat against the unit's kitchenette door. A staff member intervened and Resident # 003 released Resident # 005 who sustained a bruise on the left side of her/his neck. The police were notified and Geriatric Psychiatry was consulted. Resident # 005 was transferred to another Resident care unit.

Resident # 003's most recent plan of care was reviewed by the inspector. Staff had not reviewed and revised the Resident's plan of care when the Resident's care needs changed as a result of the incident on a date in February 2013.

On March 6, 2013 discussion with staff member # S103 who indicated she was responsible to review and revise Resident # 003's plan of care which she had failed to do. Staff member #S103 indicated she would update the Resident's plan of care to include behaviour mapping and safety checks.

On March 6, 2013 discussion with Clinical Manager # S102 who confirmed that it was staff member # S103's responsibility to review and revise Resident # 003's plan of care. [Log # O-000183-13] [s. 6. (10) (b)]

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's plan of care is reviewed and revised when the Resident's care needs change, 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 :

The licensee failed to comply with O. Reg 79/10, s. 8(1)(b) in that the home has not complied with their Fall Policy, part of their Fall Prevention and Management Program as required by O. Reg 79/10, s.48(1)(1).

O. Reg 79/10, s. 48(1)(1) provides that every home shall have a Falls Prevention and Management Program developed and implemented to reduce the incidence of falls and the risk of injury. A component of the home's Falls Prevention and Management Program is their Fall Interventions Risk Management (FIRM) Program – National Policy # LTC-N-75 revised March 2012.

The FIRM Program – National Policy # LTC-N-75 revised March 2012 directs registered staff members to complete the home's Fall Risk Assessment Tool (FRAT) on admission and update the admission assessment/plan of care. On a date in December 2012 a registered staff member completed the home's FRAT, the results of which indicated that Resident # 004 was at a medium risk of falls. The registered staff member did not update Resident # 004's plan of care to identify that the Resident was at risk of falls.

Resident # 004's progress notes on a date in January 2013 indicate that the Resident was ambulating in the hallway and fell. According to the Resident Fall Documentation form completed on the day of the fall, the Resident stated that she/he had felt dizzy before falling. The home's Fall Interventions Risk Management (FIRM) Program – National Policy # LTC-N-75 revised March 2012, directs registered staff members to complete the FRAT when there has been a change in the Resident's health status. The registered staff member did not complete the FRAT after this change in Resident # 004's health status.

Resident # 004's progress notes on a date in January 2013 indicate that the Resident was ambulating in the hallway and fell. The home's Fall Interventions Risk Management (FIRM) Program – National Policy # LTC-N-75-ON revised March 2012, directs registered staff members to initiate and complete a Neurological Flowsheet when a Resident has hit their head. The registered staff initiated a Neurological Flowsheet for Resident # 004 but did not complete it. Resident # 004's neurological status was to be checked every 30 minutes for 2 hours, every hour for 6 hours, every 4 hours for 8 hours and every 8 hours for 56 hours. Resident # 004's Neurological Flowsheet indicates that the Resident's neurological signs were not checked on a date in January 2013 at 22:30 and 23:30, nor the following day at 00:30, 01:30, 02:30,

07:30, 11:30, nor in the evening.

Resident # 004's progress notes on a date in February 2013 at 06:30 indicate that the Resident "continues on head injury routine sleeping most of the night". Resident # 004 neurological status was to be checked every 30 minutes for 2 hours, every hour for 6 hours, every 4 hours for 8 hours and every 8 hours for 56 hours. Resident # 004's Neurological Flowsheet indicates that the Resident's neurological signs were not checked during the night shift of a date in January 2013 at 23:30 and extending into the following day.

Discussion with the home's Executive Director and a Clinical Manager who confirmed that there were gaps in the documentation of Resident # 004's Neurological Flowsheet that was initiated on a date in January 2013.

On a date in February 2013 at 19:05 Resident # 004 fell, hit her/his head and was transferred to the hospital. The Resident was admitted to the hospitals' Intensive Care Unit where she/he died the following day as a result of the head injury sustained due to her/his fall on a date in February 2013.

Resident # 004's progress notes on a date in February 2013 indicate that the registered nurse who assessed the Resident immediately after the Resident's fall noticed a change in the Resident's level of consciousness , Resident's eyes were opened, staring, looked confused and drowsy.

The home's Fall Interventions Risk Management (FIRM) Program – National Policy # LTC-N-75-ON revised March 2012, directs registered staff members to initiate a Neurological Flowsheet when a Resident has hit their head. There is no documentation in Resident # 004's health record that a Neurological Flowsheet was initiated on a date in February 2013 immediately after the Resident's fall.[Log # O-000185-13] [s. 8. (1)]

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 policies related to the Falls Prevention and Management Program are complied with, to be implemented voluntarily.

WN #3: 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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10, s. 26(3)10 in that a Resident's plan of care was not based on an interdisciplinary assessment with respect to the Resident's risk of falls.

Resident # 004 was admitted to Carlingview Manor on a date in December 2012. According to the Health Assessment Form for Determination of Eligibility for Long Term Care Admission on a date in July 2012, the Resident's medical diagnoses included recurrent falls. The home's Admission Screening Tool on a date in December 2012 indicated that Resident # 004 was at risk for falls. On a date in December 2012 a registered staff member completed the home's a Fall Risk Assessment tool (FRAT), the results of which indicated that the Resident was at a medium risk of falls. The Resident's plan of care did not include the results of this nursing assessment. Conversely, a Rehabilitation Assistant's assessment on a date in December 2012 indicated that this Resident was at a low risk of falling.

Resident # 004's plan of care was not based on an interdisciplinary assessment related to the Resident's risk of falls. [Log # O-000185-13] [s. 26. (3) 10.]

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 all residents plan of care are based on an interdisciplinary assess with respect to the residents' risk of falls., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours. O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.107(3)(4) in that the licensee did not ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later than one business day after the occurrence of the incident.

On a date in February 2013 Resident # 004 fell, sustained an injury and was sent to hospital. The home notified the Director via the Critical Incident Reporting System two days later [Log #O-000185-13] [s. 107. (3)]

Issued on this 19th day of March, 2013

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

Kathleen Smid