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
Jan 31, 2014	2014_284545_0002	O-000002-14	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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 16, 17, 20 and 21, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistant Executive Director, Director of Care (DOC), Business Office Manager, a Clinical Manager, Staff Development Coordinator, Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Housekeeping Aid and residents.

During the course of the inspection, the inspector(s) reviewed the health records of Resident #11 and Resident #12, the Resident Non-Abuse - Ontario Policy Index: LP-C-20-ON, Worksheet for Tracking Staff Completion of Mandatory Training for 2013, Annual Mandatory Training Day Employee Workbook for a specific registered staff, Home's investigation report and observed care and services provided to residents.

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

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for Resident #11 that sets out planned care, goals that care is intended to achieve; and clear directions to staff and others who provide direct care to Resident #11 as follows:

During interviews with the following staff: S105, S114, S115, S116, S117 and S118 it was confirmed that they were aware that Resident #11 displayed affectionate behaviour towards staff and residents through a variety of observations.

Planned care was not found in Resident #11's plan of care to address affectionate behaviour towards staff and residents. [s. 6. (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 in ensuring that the affectionate responsive behaviour be identified in the plan of care, including goals of care and clear directions to staff and others who provide care to Resident #11, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The Licensee failed to comply with O. Reg s. 53 (4) (a) in that the home did not ensure that the behavioural triggers were identified for Resident #11 responsive behaviours.

In Resident #11's care plan, revised on a specific date in October 2013, it was identified that Resident #11 was known to wander away from the dining table before meals were finished and wandered into other residents' rooms. The interventions in the care plan stated to allow Resident #11 to wander on Resident Home Area, to document behaviours including triggers and successful interventions and to provide assistance in locating Resident #11's own room. The care plan did not identify behavioural triggers for Resident #11's wandering responsive behaviour.

During interviews with staff S115, S116 and S117, they indicated that no triggers were identified in the care plan and that Resident #11 was confused and just wandered for no specific reason.

During an interview with RPN S112, it was indicated that Resident #11 usually started to wander around 2pm.

During a discussion with Clinical Manager S113, it was indicated that a referral to geriatric psychiatry was not initiated for Resident #11 because Resident #11 would not have benefited from the program as behavioural triggers were not identified for the wandering behaviour for this resident.

During an interview with RPN S114 it was indicated that some of the possible triggers for wandering behaviour of Resident #11 might be hunger, thirst or need for toileting. Behavioural triggers identified verbally by Staff S114 were not documented in the revised care plan of a specific date in October 2013.

As such the behavioural triggers for Resident #11 were not identified in the plan of care to effectively manage the resident's wandering responsive behaviour. [s. 53. (4) (a)]

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 in ensuring that the behavioural triggers for Resident #11's wandering be identified in the plan of care, to be implemented voluntarily.

WN #3: 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 failed to comply with the LTCHA, 2007 S.O. 2007, c8, s.24 (1) 2 in that an alleged sexual abuse was not immediately reported to the Director.

On a specific date in December 2013 in a progress note written by evening shift RPN it indicated that Staff S108 found Resident #11 in Resident #12's bed and observed behaviours of a sexual nature.

A review of the investigation report prepared by the Executive Director on a specific date in January 2014 confirms that the evening Charge Nurse was notified by the evening shift RPN of the alleged sexual abuse between Resident #11 and Resident #12. It was indicated that the evening Charge Nurse notified the On-Call Manager.

During an interview with staff S118, it was indicated that the Executive Director was notified of the alleged sexual abuse between two cognitively impaired residents: Resident #11 and Resident #12 that occurred on a specific date in December 2013. Staff S118 discovered the occurrence of the incident while reading the 24-hour report at the beginning of shift.

The Director was notified of the alleged resident to resident sexual abuse on a specific date in 2013; 16 hours following occurrence of critical incident. As such the Licensee did not report immediately to the Director the suspicion and the information of this resident to resident alleged sexual abuse to the Director. [s. 24. (1)]

Issued on this 6th day of February, 2014

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

Angèle Albert Ritchie