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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Oct 2, 2014	2014_199161_0022	O-000957-14	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

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): September 25, 26, 30, 2014.

During the course of the inspection, the inspector(s) spoke with an identified Resident, a Personal Support Worker, a Clinical Manager, Environmental Services Manager (ESM), interim Director of Care, Executive Director and a representative of Motion Specialties.

During the course of the inspection, the inspector(s) observed identified Residents, their bed systems and health care records, the home's policy title "Bed Entrapment" #ESP-B-65 dated March 2014, manufacturer's instructions for Carroll Healthcare Electric Echo Bed, Joerns Bed Frames EasyCare bed, and an Alternating Low Air Loss Pressure Relief System.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident.

Resident #001 was admitted to the home in August 2013 with a stage 4 pressure ulcer on his/her sacrum. On admission, the Resident's attending physician ordered a pressure relieving mattress and as such, an alternating low air loss pressure relief system mattress was installed on Resident #001's bed.

According to a Critical Incident Report, on a specified date in September 2014 Personal Support Worker #S100 found Resident #001 lying in his/her bed, crying in pain, with his/her left leg entrapped between the left bed rail and the alternating low air loss pressure relief system mattress. As Personal Support Worker #S100 assisted Resident #001 in freeing his/her entrapped left leg, a "popping" sound was heard, and the Resident cried out that his/her left leg was broken. Resident #001 was subsequently sent to hospital where he/she was diagnosed with a fractured left tibia and fibula. A cast was applied and the Resident returned to the home the following day.

On September 25, 2104 Inspectors #161 and #599 asked for and received from the ESM, a copy of the home's policy titled "Bed Entrapment" ESP-B-65 revised March 2014. The policy indicates that when a bed system is altered in any way such as changing the mattress, a safety checklist (ESP-B-65-05) will be completed to assess the risk of entrapment by the person making the bed system change.

On September 25, 2014 inspectors #161 and #559, in the presence of the ESM, observed that the mattresses on Residents #001, #002, #003, #004, #005's beds were alternating low air loss pressure relief system mattresses. Furthermore, Resident's #001, #003, #004, #005's bed rails were observed in the upright position. A further investigation revealed that the safety checklists ESP-B-65-05 related to the assessment of risk of entrapment were not completed on all 5 Residents.

On September 25, 2014 Inspectors #161 and #559 discussed with the interim Director of Care the home's policy titled "Bed Entrapment" #ESP-B-65 revised March 2014. The interim Director of Care confirmed that the safety checklists (ESP-B-65-05) were not used to assess the risk of entrapment when Resident #001, #002, #003, #004 and #005's mattresses were changed to alternating low air loss pressure relief system

mattresses. This was also confirmed by the home's Executive Director. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

The licensee had failed to ensure that the plan of care for Residents #001, #003, #004, #005 sets out clear directions to staff who provide care to these Residents.

On September 25, 2014 inspectors #161 and #559 observed the following:

Resident #001's care plan dated August 2014 which was in effect at the time of the incident in September 2014, did not include that the Resident was on an alternating low air loss pressure relief system mattress nor that bed rails were used.

Resident #003's care plan dated August 2014 dId not include that the Resident is using bed rails while on an alternating low air loss pressure relief system mattress.

Resident #004 and #005 have alternating low air loss pressure relief system mattress on their beds. Their most recent care plans dated June 2014 and August 2014 respectively, did not contain this information. [s. 6. (1) (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 there are clear directions in the plans of care for all Residents on a therapeutic mattress and using bed rails, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

The licensee has failed to ensure that staff use all equipment in the home in accordance with manufacturers' instructions.

Inspector #161 reviewed a Critical Incident Report whereby on a specified date in September 2014 Personal Support Worker #S100 found Resident #001 lying in his/her bed, crying in pain, with his/her left leg entrapped between the left bedside rail and the therapeutic mattress. The mattress was an alternating low air loss pressure relief system mattress.

On September 25, 2014 inspectors #161 and #559, in the presence of the ESM, observed that the mattresses on Residents #001, #002, #003, #004, #005's beds were alternating low air loss pressure relief system mattresses. According to the manufacturer's instructions which were provided to the inspectors by the homes' ESM, the identified low air loss pressure relief system mattresses must be secured to the bed frame.

On September 25, 2014, in the presence of the ESM, Inspectors #161 and #559 observed that the low air loss pressure relief system mattresses on Resident #002, #003, #004, #005's were not secured to the bed frames, contrary to the manufacturers' instructions. [s. 23.]

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 when a Resident has a therapeutic mattress, staff follow the manufacturer's instructions, to be implemented voluntarily.

Issued on this 2nd day of October, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2014_199161_0022
Log No. / Registre no:	O-000957-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 2, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	CARLINGVIEW MANOR 2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY DROUIN

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee will ensure compliance by ensuring that (1) where bed rails are used in conjunction with therapeutic mattresses, Residents will be assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize risk to the identified Residents; (2) Steps will be taken to address the assessed risks and (3) education to all nursing staff related to (1) and (2).

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident.

Resident #001 was admitted to the home in August 2013 with a stage 4 pressure ulcer on his/her sacrum. On admission, the Resident's attending physician ordered a pressure relieving mattress and as such, an alternating low air loss pressure relief system mattress was installed on Resident #001's bed.

According to a Critical Incident Report, on a specified date in September 2014 Personal Support Worker #S100 found Resident #001 lying in his/her bed, crying in pain, with his/her left leg entrapped between the left bed rail and the alternating low air loss pressure relief system mattress. As Personal Support Worker #S100 assisted Resident #001 in freeing his/her entrapped left leg, a

"popping" sound was heard, and the Resident cried out that his/her left leg was broken. Resident #001 was subsequently sent to hospital where he/she was diagnosed with a fractured left tibia and fibula. A cast was applied and the Resident returned to the home the following day.

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On September 25, 2014 Inspectors #161 and #559 discussed with the interim Director of Care the home's policy titled "Bed Entrapment" #ESP-B-65 revised March 2014. The interim Director of Care confirmed that the safety checklists (ESP-B-65-05) were not used to assess the risk of entrapment when Resident #001, #002, #003, #004 and #005's mattresses were changed to alternating low air loss pressure relief system mattresses. This was also confirmed by the home's Executive Director. [s. 15. (1) (a)] (161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID

Service Area Office /
Bureau régional de services : Ottawa Service Area Office