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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 11, 2015	2015_199161_0002	O-000875-14 X O-001060-14	Follow up

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

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 15, 16, 2015

The Inspector(s) conducted two follow-up inspections; Log #O-000875-14 and Log #O-001060-14. The Inspector(s) reviewed Resident's health care records, educational materials related to Bed Rail Entrapment and observed four Resident bed systems.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistant Executive Director, Interim Director of Care, Staff Development Co-ordinator and the Environmental Services Manager.

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

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2014_199161_0022	161
O.Reg 79/10 s. 229. (10)	CO #001	2014_288549_0033	161

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. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. LTCHA 2007, S.O. 2007, c. 8, s. 76 (7) states that every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

Specifically, the licensee failed to comply with O.Reg. 79/10, s. 221(4) in that the licensee did not ensure that the training required under paragraph 4 of subsection 76 (7)6, of the Act includes training in the application, use and potential dangers of physical devices used to restrain residents and personal assistance services devices.

The licensee failed to complete education for all nursing staff regarding bed rail entrapment, specifically: where bed rails are used, (a) the Resident is assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the identified Residents (b) steps taken to address the assessed risks taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addresses, including height and latch reliability. Education in these areas was to be complied with by November 3, 2014.

On January 15, 2015 a follow–up inspection was conducted whereby the Interim Director of Care identified the Staff Development Coordinator as the person responsible for the education of all the nursing staff related to the Compliance Order issued on October 2, 2014. Inspector #161 asked for and received from the Staff Development Coordinator the Bed Rail Entrapment In-service Records for those nursing staff who attended these education sessions. It is documented that 140 nursing staff had attended these education sessions. The Staff Development Coordinator identified the Staffing Clerk as having a list of all nursing staff employed at the home. Inspector #161 in the presence of the Staff Development Coordinator asked for and received from the Staffing Clerk an "Active Employee Seniority List." It is noted that a total of 140 nursing staff had attended the Bed Entrapment In-services, while the remaining 75 nursing staff did not receive the Bed Rail Entrapment education as specified in the Compliance Order. This was verified with the Interim Director of Care. She indicated that she would immediately put a plan in place to address the need to provide education to the remaining nursing staff regarding Bed Rail Entrapment as per Compliance Order #001 previously issued October 2, 2014 under Inspection #2014_199161_0022. [s. 76. (7) 6.]

Issued on this 11th day of February, 2015

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

Original report signed by the inspector.