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
Jul 13, 2015	2015_225126_0024	O-002184-15	Complaint

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 8,9,10,13, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, one Clinical Manager, one Registered Practical Nurse and several residents.

The following Inspection Protocols were used during this inspection:

Medication
Nutrition and Hydration

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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to Resident #02 as specified in the plan.

On July 8, 2015, Inspector #126 conducted a complaint inspection and one of the component was related to the safe administration/process of a specific anti-coagulant.

On July 9, 2015, discussion held with the Assistant Director of Care(ADOC) who indicated that out of the 5 physicians in the home, only one was prescribing that specific anti-coagulant and the other physicians were prescribing alternate anti-coagulants.

The health care records of three residents receiving that specific anti-coagulant on a daily basis were reviewed for the prescription, the administration of the medication and the monitoring of Prothrombin Time International Normalized Ratio Therapeutic Range (INR).

It was noted that Resident #02 was on that specific anti-coagulant on a daily basis with an INR level to be done on a weekly basis. On a specific date in June 2015, Resident #02 was prescribed an antibiotic and on following day the physician ordered " to check the INR twice a week while on the antibiotic". The nurse who transcribed the order, wrote in the "Laboratory Binder" to have the INR done twice a week." Therefore the INR should have been done on a specific Friday, the next Monday and the following Friday of June 2015.

On July 10, 2015, discussion held with Clinical Manager S#100 who indicated that the laboratory visit the home on Monday and Friday. Clinical Manager S#100 reviewed Resident #02 health care record with Inspector #126 and was unable to find the confirmation or result that an INR was done on that specific date of Monday June 2015.

The second INR was not done as prescribed by the physician and as specified in the plan of care. The INR was done weekly and remain in the therapeutic range. [s. 6. (7)]

Issued on this 13th day of July, 2015

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

Original report signed by the inspector.