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
Sep 29, 2015	2015_287548_0021	O-001389-14, O-002566-15, O-002565-15, O-002491-15	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

RUZICA SUBOTIC-HOWELL (548)

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): September 8,9,10, 2015

During the course of the inspection the inspector: toured resident care areas, reviewed residents' health care records, reviewed, zero tolerance of abuse and neglect policy, missing person policies, fall prevention program, internal incident documentation, observed staff to resident interactions.

During the course of the inspection, the inspector(s) spoke with Residents, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs),RAI Coordinator(Backup), Environmental Services Manager and Regional Manager.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 failed to ensure that the care set out in the plan is provided to the resident as specified in the plan.

An inspection was conducted related to Critical Incident Report forwarded to the MOHLTC.

Resident #001 has preexisting medical diagnoses.

The health record was reviewed. The resident's current care plan indicated that there is a past history of aggression with other residents and is territorial.The care plan specified the implementation of a yellow barrier band to be placed at the threshold of resident's #001 room to discourage other residents from entering in.

On a specified day in September 2015 Inspector #548 observed the resident and the resident's room. There was no yellow barrier band placed at the threshold of the resident's room. The resident was observed again in the afternoon and at both times the resident was observed to be quiet with no behaviours.

On specified day in September 2015 all staff interviewed indicated that the barrier band is used to deter other resident's from entering the resident's room. A registered practical nurse (RPN) indicated that the band had been missing since early August, 2015 and both Personal Support workers concurred. The RPN indicated that a verbal request for its replacement was made and that she was notified that the home was out of stock.

On a specified day in September, 2015 during an interview the Director of Care (DOC) indicated that a yellow barrier at the threshold of the room is required for the resident as it minimizes the resident's response to others when residents' attempt to enter the room. The DOC indicated she had spoken with the Environmental Services Manager (ESM) who indicated that the barrier band would have been replaced if notified appropriately through a work order and that the home always has them in stock. The DOC indicated that she has requested to have the barrier band replaced by ESM.

The following day Inspector #548 observed that there was no yellow barrier band placed at the threshold of the resident's room. The ESM informed the inspector in the afternoon that the band was being replaced. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The Ministry of Health was informed on specified day in June, 2015 that resident #003 had a fall and was sent to hospital.

The health record was reviewed. It is recorded that the resident had a witnessed fall in the hallway on a specified day in June 2014 where the resident sustained an injury. The resident's POA and physician were informed and the resident was sent to hospital. The resident returned to the home and passed away a few days later.

The home's most recent assessment of the resident identified that the Resident #003 was high risk for falls. The resident was being seen by physiotherapy and required support for mobility. Staff were to provide the resident reminders to use the walker and to supervise and redirect the resident.

On a specified day in September, 2015 during an interview S#100 RPN indicated that the resident was cognitively able to mobilize with the walker but was physically unsteady. S#106 PSW concurred and indicated that the resident mobilized with the walker independantly and was supervised by staff in order to do so. S#100 RPN indicated that the home has a process to assess residents post-falls.

On September 9, 2015 the Director of Care (DOC) indicated that the home's process for witnessed and unwitnessed falls requires a post fall assessment. The DOC indicated that the document titled: Resident Fall Documentation; is a tool specifically designed for post fall assessments and should be completed after each fall.

Upon record review it was noted that on the home's incident reports there are two incidents of unwitnessed falls reported related to the Resident #003 in May, 2014. The resident sustained an injury post each fall. There are no post fall assessments completed for these two falls and for the fall on a specified day in June, 2014. The DOC confirmed that if there is no record of post fall assessments completed on the Resident Fall Documentation then the post-fall assessments were not done. [s. 49. (2)]

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Issued on this 30th day of September, 2015

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

Original report signed by the inspector.