Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 1, 2011	2011_117_2420_01Feb115353	Critical Incident Log # O-000231

Licensee/Titulaire

Revera Long Term Care Inc.
55 Standish Court, 8th floor
Mississauga ON
L5R 4B2
Fax: (289).360.1201

Long-Term Care Home/Foyer de soins de longue durée

Carlingview Manor
2330 Carling Avenue
Ottawa, ON
K2B 7H1
Fax: (613) 820-9774

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the abuse of a resident.

During the course of the inspection, the inspector spoke with the home's Executive Officer, to the home's Director of Care, to a Registered Nurse, to a Personal Support Worker and to the identified resident.

During the course of the inspection, the inspector reviewed the identified resident's health care record and observed a resident room.

The following Inspection Protocol was used during this inspection:

- Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

2 WN
1 VPC
1 CO: #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. On January 28 2011, at approximately 11 am, a Personal Support Worker was seen by a Personal Support Worker student to be "beating" and pulling off the shirt of a resident, in the resident's room. This fact was reported in person to the Personal Support Worker student's school supervisor at approximately 12:00 on January 28, 2011 and to the home's Administrator in writing at approximately 14:45 on January 28, 2011.

2. The Personal Support Worker student reported that when she told the Personal Support Worker that this was wrong, the Personal Support Worker responded by saying that the resident had bit her and that was why she hit the resident.

3. The resident's plan of care indicates that if the resident is aggressive or resistive to care, staff are to leave the resident and return within 5-10 minutes. Staff are also directed to distract the resident through conversation in attempt to get the resident to accept care.

4. The home's Administrator and Director of Care interviewed the Personal Support Worker who was seen to be "beating" the resident on January 29, 2011. They state that the Personal Support Worker told them that she did not stop, leave the resident and return within 5-10 minutes, as indicated in the resident's plan of care, when the resident was physically aggressive and resistive to care on January 28, 2011.

5. The home's Documentation Registered Practical Nurse assessed the resident at approximately 15:30 on January 28, 2011. It was noted that the resident had new and old bruises to right hand and forearm. The causes of the bruises are unknown.

Compliance Order #001 was faxed to the licensee- See Order Report

Inspector ID #:	# 117

WN #2: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. The resident's plan of care indicates that if the resident is aggressive or resistive to care, staff are to leave the resident and return within 5-10 minutes. Staff are also directed to distract the resident through conversation in attempt to get the resident to accept care.

2. The home's Administrator and Director of Care interviewed the Personal Support Worker who was seen to be "beating" the resident on January 29, 2011. They state that the Personal Support Worker told them that she did not stop, leave the resident and return within 5-10 minutes, as indicated in the resident's plan of care, when the resident was physically aggressive and resistive to care on January 28, 2011

Inspector ID #:	# 117

Additional Required Actions:

VPC #1 - 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 regarding the need to ensure that the care set out in the identified resident's plan of care is provided to the resident as specified in her plan, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: Date:	Date of Report: (if different from date(s) of inspection). February 9, 2011