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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 16, 2016	2016_417178_0018	029588-16	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

SUSAN LUI (178)

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): October 25, 26, 27, 2016.

This Complaint Inspection is related to prevention of falls. Critical Incident Intake #027828-16, involving the same resident and incident, was also inspected as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Associate Executive Director, an identified Clinical Manager, registered nursing staff, personal support workers (PSWs).

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provided direct care to a resident had convenient and immediate access to the plan of care.

Resident #001 was known to have cognitive impairment, be ambulatory with a walker, and to wander throughout the resident home area.

Review of progress notes for resident #001 revealed that on an identified date the resident fell for the first time in the home, and sustained a serious injury. The resident was transferred to hospital where the injury was treated, and returned to the home six days later. On the evening of the second day the resident was admitted back in the home, the resident fell for a second time, and fell for a third time approximately two months later.

Review of the resident's plan of care revealed that after the resident's second fall, interventions were initiated to prevent and mitigate future falls, which included the use of a chair and bed alarm, and placing a falls mat at the resident's bedside while in bed. These interventions were documented on the electronic medication administration record (eMAR), which only registered nursing staff can access. The interventions were not added to the resident's care plan or Kardex, which PSWs can access, until after the resident's third fall, which occurred two months after the first fall incident.

Interview with Clinical Manager #105 on October 27, 2016 confirmed that PSWs access a resident's plan of care via the Kardex on the home's electronic documenting system,

Point of Care, and that PSWs cannot access a resident's eMAR. Clinical Manager #105 confirmed that resident #001's written plan of care for Falls Prevention was not immediately accessible to the PSWs providing his/her care until after the resident's third fall, when the interventions to prevent falls were added to the resident's Kardex. [s. 6. (8)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

Resident #001 was known to have cognitive impairment, be ambulatory with a walker, and to wander throughout the resident home area.

Review of progress notes for resident #001 revealed that on an identified date, the resident fell and sustained a serious injury. This was the resident's first fall while in the home. The resident was transferred to hospital where the injury was treated, and returned to the home six days later. On the second day back in the home, the resident fell for a second time. The resident was thought to have sustained no injury with the second fall, but approximately two weeks later it was determined that the resident had encountered complications in the same area injured in the first fall, and required transfer back to hospital to receive further treatment for the injury.

During interviews on October 26, and October 27, 2016, the home's Associate ED, Clinical Manger #103, and RN #104 all confirmed that the home's process is to assess resident for falls risk using their Falls Risk Assessment Tool (FRAT). This assessment is to be completed on admission, with a change in condition, and on return from hospital with a change in condition.

Review of resident #001's record revealed that the resident was not reassessed for falls risk using the FRAT when the resident returned to the home after the first hospitalization to treat the serious injury caused by the first fall. No FRAT was conducted for the resident until more than a week after returning from hospital, during which time the resident fell for a second time.

Interview with the Clinical Manager #105 on October 27, 2016, confirmed that the resident should have been reassessed for risk for falls using the FRAT when the resident returned to the home from hospital after being treated for the serious injury sustained in the first fall incident.

Review of resident #001's plan of care revealed that the plan was not revised to include a

plan for prevention of falls after the resident's first fall incident on an identified date. On return to the home six days later after receiving treatment for the serious injury sustained in the first fall incident, the only revision made to the resident's plan of care with regards to falls prevention was to add a task to the PSW's electronic documentation record, Point of Care (POC) which stated that the resident was to be monitored for safety every 30 minutes, to make sure the resident did not try to walk or transfer independently.

After the resident fell for a second time, two days after return from hospital, the plan of care was revised to include chair and bed alarms, and a falls mat to be placed at the bedside when the resident was in bed. These interventions were documented on the resident's electronic medication administration record (eMAR). [s. 6. (10) (b)]

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:
-staff and others who provide direct care to the resident have convenient and immediate access to the plan of care
-the the resident is reassessed and the plan of care is reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.

On October 27, 2016 at 1134h, the inspector observed the door to the medication room on an identified unit to be open wide, revealing a medication cart inside. The medication cart was not locked, and residents' medications were present and accessible inside the unlocked drawers of the cart. The medication room is located directly across from the elevators, and would be in full view of anyone exiting the elevator.

The registered staff member in charge of the unit, staff #100, was observed to be standing in front of the nursing station approximately 15 feet away from the medication room. The registered staff member was leaning into the nursing station, speaking on the phone, and did not appear to see the inspector enter the medication room. The inspector was alone in the medication room for approximately two minutes until registered staff #100 entered to the medication room. Staff #100 confirmed that he had not seen the inspector enter the medication room, and that the medication room should have been kept locked when not in use.

During an interview on October 27, 2016, Clinical Manager #103 confirmed that the registered staff on duty on the 5th floor should have ensured that the door to the medication room was kept locked when not in use. [s. 130. 1.]

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 all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

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Issued on this 17th day of November, 2016

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

Original report signed by the inspector.