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
Feb 7, 2017	2017_617148_0001	032460-16, 033490-16, 034153-16	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

AMANDA NIXON (148)

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): January 10-13 and 16, 2017.

This inspection included three complaint intakes, including issues related to continence care, skin and wound care, provision of assistance with activities of daily living, admission and discharge and medication administration.

During the course of the inspection, the inspector(s) spoke with the home's Associate Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Clinical Managers, Registered Nurses, Registered Practical Nurses (RPN), Physiotherapist Assistant, Personal Support Workers (PSW), family and residents.

In addition, the Inspector also observed the provision of care and services to residents, staff to resident interactions and the resident's environment. The Inspector reviewed identified resident health care records, including plans of care, skin and wound assessments, medication administration records and documentation maintained by personal support workers.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to resident #003 in accordance with the directions for use specified by the prescriber.

Resident #003 was ordered three medications by the physician on a specified date in November 2016, two of which were to continue into early 2017.

Resident #003 reported to the Inspector that he/she did not receive all of the medications as ordered. The medication administration record for December 2016 indicates that all three of the medications were placed on hold on a specified date.

A progress note and telephone order taken by RPN #107, indicates that the resident returned from a follow up appointment with orders to discontinue one of the three medications. The Inspector spoke with RPN #107, who stated the order was to discontinue only one of the medications and that the other two medications were to continue. The telephone order taken by RPN #107 was initially processed by RPN #110. The Inspector reviewed a copy of the order with RPN #110, who indicated that it was her understanding that all of the medications were to be placed on hold.

On January 13, 2017, the Inspector reviewed the above findings with the DOC and ADOC. Both managers indicated that the telephone order instructed the hold for one medication; there was no order to support the hold of the other two medications. It was reported to the Inspector at a later date, that the licensee had initiated an investigation into the medication error and RPN #110 had been placed on administrative leave pending the results of the investigation.

The physician ordered medications were not provided to resident #003 in accordance with the directions for use by the prescriber. [s. 131. (2)]

(Log 034153-16)

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 medication, including eye drops, are administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 has an individualized plan, as part of his or her plan of care, to promote and manage bladder continence based on an assessment and that the plan is implemented.

Resident #001 is incontinent of urine and uses continence care products (brief) during the day and night. The resident is potentially continent of bowel some of the time and receives toileting. As noted by the resident and health care record, the resident requires assistance with many activities of daily living due to physical limitations and is administered a diuretic twice a day.

The Inspector spoke with Resident #001, who described him/herself as having no control over bladder. The resident reported that during the day he/she is provided with toileting and change of brief between 0730-0800 hours, 1100-1130 hours,1600 hours and at bedtime care, around 2130 hours. The resident indicated that he/she is on scheduled change times, therefore at 1100-1130 and 1600 hours the resident will call for assistance and the toileting/change will be provided. The resident does not believe that he/she can be changed outside of these scheduled hours. When asked by the Inspector, the resident

reported that he/she will urinate in the brief within 30-60 minutes of a meal and will remain in this brief until the scheduled change time.

The Inspector observed the provision of toileting/continence care for the resident over the course of the morning on January 10, 2017. In addition to several visits with the resident over the same morning, the Inspector was able to confirm that the resident was not provided with toileting or change of brief between 0810-1135 hours. When the resident was approached by the Inspector at 1100 hours, the resident described him/herself as wet and uncomfortable. At this time the resident looked at the clock on the wall and decided it was time to call for staff to assist him/her with a change; the resident activated the call bell. Minutes later the Inspector noted the call bell had been deactivated. At 1110 hours, the Inspector re-approached the resident who indicated that a staff person was in and indicated that they had to get the lift to assist the resident. At 1130 hours, resident #001 activated the call bell, PSW #103, indicated to the Inspector that he had noted the call bell activation. He proceeded to speak with PSW #102; at 1136 hours, PSW #102 entered the resident's room with PSW #103 to provide toileting/continence care.

Later that same day at approximately 1415 hours, the Inspector approached resident #001 in the resident's room. The resident reported that he/she was provided with toileting and brief change just before lunch. The resident further reported that she had not been provided any toileting or change of brief since that time. When asked by the Inspector, the resident described him/herself as wet and uncomfortable.

The Inspector spoke with three PSW staff members on the unit, including PSW #102 and #103. Two staff members described the resident as having no control over bladder but will usually have some control with bowel. PSW #102, described the toileting schedule for this resident during the day shift to be during morning care and before lunch and sometimes around 1400 hours, depending if the resident needs the change. At these times the resident is toileted and provided a brief change; the staff member noting that the brief is wet at these times. Two PSWs indicated that the resident is able to request changes to the brief and will call for assistance when needed. When asked by the Inspector, it was reported that staff do not approach the resident to check for wetness or need for toileting/changes as the resident is able to call when toileting or a change is required.

The most recent Minimum Data Set Assessment describes the resident as incontinent of bladder and frequently incontinent of bowel, noting the resident wears briefs for containment. The plan of care indicates that the resident is incontinent of bowel and

bladder and wears an extra large brief. Staff are to monitor for change as needed to ensure the resident is kept clean and free of odor. The plan of care further describes that the resident requires assistance with toileting and transfers due to the resident's physical limitations. Under the item of toileting, the plan describes that the resident is to be toileted every two hours and as needed.

Resident #001 has several factors contributing to incontinence. The resident may be capable of communicating when toileting and brief changes are required, however, has a belief that a schedule for toileting and changes is in effect. The staff who provide continence care are aware of the resident's lack of bladder control and describe that the resident is wet when changes are provided and rely on the resident to identify when changes are required. The plan in place is not individualized to manage the resident's bladder incontinence. In addition, the toileting plan currently in place, described as every two hours, was not provided to resident #001 during the observation period.

(Log 033490-16) [s. 51. (2) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Resident #003 was ordered eye drops on a specified date. In review of the medication administration record for a specified month, it was indiacted that on two subsequent days, during the day shift the eye drops were not available, however, on the same two days the evening shift RPN #110, administered the eye drops.

The Inspector spoke with RPN #110, regarding the unavailability of the eye drops and her documentation that the eye drops were administered during the evening shift. RPN #110 indicated that the eye drops for resident #003 were not able to be found and she used the eye drops from resident #004.

On January 13, 2016, the Inspector brought forward the issue of infection control and use of a co-resident's eye drops. The DOC and ADOC reviewed the file of resident #004 and confirmed that the resident was on the same eye drops during the same period as resident #003. In addition, the DOC was able to locate the partially used bottle of eye drops labelled for resident #004.

Staff member RPN #110 did not participate in the implementation of the infection prevention and control program when she used the eye drops of resident #004 for resident #003.

(Log 034153-16) [s. 229. (4)]

Issued on this 7th day of February, 2017

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

Original report signed by the inspector.