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_0004	001540-17	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 19, 2017

This complaint is related to the unexpected death of an identified resident.

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

The Inspector reviewed the identified resident's health care record, including plans of care, medication administration records and documentation maintained by personal support workers as it relates to bowel protocol and policies related to the bowel management program.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 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 :

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The physician orders for resident #001 indicate the following as part of the resident's bowel protocol:
Day 2 no bowel movement– fiberite with fluids, prunes or prune juice
Day 3 no bowel movement – 30 mls milk of magnesia if no bowel movement on day 3 and fiberite with fluids, prunes or prune juice.
Day 4 no bowel movement – 1 dose glycerin suppository if no bowel movement on day 4 and give fiberite with fluids, prunes or prune juice.
Day 4 no bowel movement - if no results from glycerin suppository in 6 hours, give enema 1 dose

A review of the health care record indicated that resident #003 has a history of constipation, as demonstrated by the nutritional plan of care, the pharmacist medication review noting use of PRN laxatives, the physician order of daily laxatives, and an assessment completed by geriatric outreach.

Resident #001 was sent to hospital on a specified date, by Clinical Manager #109 who noted distended abdomen and shortness of breath. RN #104 contacted the hospital on the evening of the same day and was informed that the resident would be admitted.

As described by three registered nursing staff members, the bowel movements of residents are recorded by the PSWs in Point of Care. Registered nursing staff will review the complex alert report and/or Point Click Care dashboard, which will indicate those residents who have been more than three days without a bowel movement. The nursing staff will then initiate bowel protocol as ordered. In review of the complex report used by staff it was noted that day two of no bowel movement, is not reported.

The resident's last recorded bowel movement was six days prior to the resident admission to hospital, in the days leading up to the hospital admission the bowel protocol had not been implemented. The Inspector spoke with the day nurse and evening nurse that was responsible for this resident on the day prior to the resident's admission to hospital. Both nursing staff members indicated that the resident would have been on day three no bowel movement, but neither staff could recall having had any notification that the resident's last bowel movement was five days prior. In speaking with RN #104, it was noted that no bowel protocol would have been implemented after the resident experienced emesis, which began on the evening prior to the resident being sent to hospital by Manager #109.

The Inspector reviewed the previous months medication administration records and bowel movement monitoring records and found there to be instances when the bowel protocol, as ordered by the physician, was not implemented for resident #001.

Resident #001 did not have the bowel protocol administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with O.Regulation, 79/10, s.30, s.48 and s.51, the licensee is required to have in place a continence care and bowel management program whereby relevant policies, procedures and protocols are developed and provides for methods to reduce risk and monitor outcomes.

The licensee's Continence Care policy #LTC-E-50, last revised May 2013, describes that daily monitoring of a resident's bowel and bladder outputs will be documented. The PSW will notify the nurse if the resident has not had a bowel movement in more than 48 hours.

As indicated by WN #1, a review of resident #001's health care record demonstrated that the physician ordered bowel protocol was not consistently implemented for the resident when no bowel movements were recorded. The Inspector spoke with three registered nursing staff, who reported that they are alerted to changes in bowel patterns through use of a Point Click Care report known as the complex alert report. This report allows the nurse to monitor those residents who have been without a bowel movement for 3, 4, 5 days and so on. The data in this report is fed by documentation maintained by PSW staff members in Point of Care. PSW #108 and the registered staff interviewed, reported that the electronic report is the communication method used for bowel patterns. Bowel management, including residents with 2 or 3 days without a bowel movement, are not usually discussed at shift reports or reported verbally to nursing staff. On further discussion with nursing staff, it was determined that at this time there is no mechanism for notification of resident's who have not had a bowel movement in more than 48 hours.

The policy which describes PSWs are to notify nursing staff of a resident who has not had a bowel movement in more than 48 hours, is not complied with my staff members. Current methods of bowel monitoring, primarily alert staff when a resident has had no bowel movement in three days or more. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible of an unexpected or sudden death, including a death resulting from an accident or suicide.

On a specified date, resident #001 was sent out to hospital due to a change in health status. The evening RN #104 contacted the hospital on the same day and was provided with an updated on the resident's health status. Three days later the licensee was informed that the resident had passed away in hospital on the same day the resident was sent out to hospital. The Inspector spoke with the Clinical Manager for this floor and the home's AED who were not able to provide for the licensee's notification to the Director.

The Director was informed of the unexpected death by way of complaint through the ActionLine. The licensee did not inform the Director immediately of the unexpected death as required. [s. 107. (1) 2.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that contact was maintained with resident #001, who was on a medical absence, or with the health care provider, in order to determine when the resident will be returning to the home.

On a specified date, resident #001 was sent out to hospital due to a change in health status. The evening RN #104 contacted the hospital on the same day and was provided with an updated on the resident's health status, including admission to hospital. It was demonstrated by interviews and record review that the registered nursing staff responsible to maintain contact with the health care provider did not do so over the course of the next two days. On the third day the licensee was informed that the resident had passed away in hospital on the same day the resident was sent out to hospital.

The licensee did not maintain contact with the resident or health care provider during a medical absence. [s. 141. (1)]

Issued on this 1st day of March, 2017

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

Original report signed by the inspector.