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
Jun 12, 2017	2017_617148_0016	024317-16, 028831-16, 029647-16, 031402-16, 033119-16, 007720-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 8, 9 10 and 12, 2017

This inspection included six critical incident reports, four of which were related to alleged resident abuse and two related to injury that resulted in hospital transfer and significant change in health status.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director (ED), Assistant Executive Director (AED), Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW) and residents.
In addition, the Inspector reviewed the health care records of identified residents in addition to the home's investigation data into alleged abuse, as applicable. The Inspector observed resident care and services, along with resident to resident and staff to resident interaction.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that in making a report to the Director with respect to an alleged, suspected or witnessed incident of abuse of a resident by anyone the written report shall include: a description of the individuals involved in the incident, including, names of all residents involved in the incident, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

A critical incident report (CIR) was submitted to the Director on a specified date, describing the alleged staff to resident abuse of resident #007. The CIR was reviewed by the Inspector, ED and AED and it was concluded that the CIR did not include all staff members involved in the incident, including the name of the accused staff person and a registered nurse responding to the incident. [s. 104. (1) 2.]

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that when required to inform the Director of an incident make a report in writing to the Director setting out the following with respect to the incident: a description of the individuals involved in the incident, including, the names of any residents involved in the incident, the names of any staff members or other persons who were present at or discovered the incident, and the names of staff members who responded or are responding to the incident.

A critical incident report (CIR) was submitted to the Director on a specified date, describing the fall of resident #005 resulting in an injury, transfer to hospital and reported significant health change. The CIR was reviewed by the Inspector, ED and AED and it was concluded that the report did not include the residents name or the PSW staff person who was present at the time of the fall.

A critical incident report was submitted to the Director on a specified date, describing the injury of unknown cause of resident #006 that resulted in transfer to hospital. The CIR was reviewed by the Inspector, ED and AED and it was concluded that the report did not include the surname of the resident or the PSW and RPN staff person involved with the discovery of the injury. [s. 107. (4) 2.]

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Issued on this 12th day of June, 2017

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

Original report signed by the inspector.