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 22, 2017	2017_658178_0008	002771-17, 008048-17, 008174-17, 009155-17, 011383-17	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

SUSAN LUI (178)

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): June 8, 9, 12, 13, 14, 15, 2017.

This inspection included five critical incident reports, three of which were related to resident abuse or neglect, and two related to falls with injuries.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), an identified Clinical Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSWs) and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

Resident #005's plan of care indicates that the resident has cognitive impairment, is at risk for falls, and requires assistance for all activities of daily living (ADLs).

Review of an identified Critical Incident report indicated that on an identified date, resident #005 was transferred onto the toilet by two Personal Support Workers (PSWs). The PSWs did not return to remove the resident, and the resident was found approximately two hours later by the PSW on the subsequent shift. The resident was found sitting on the toilet. The resident was uninjured.

Review of resident #005's plan of care in place at the time of the incident indicated that the resident was not to be left unattended on the toilet. Privacy was to be maintained, but the staff was to stay in the immediate area.

During an interview with Inspector #178 on June 13, 2017, PSW #108 indicated that he was the primary PSW caregiver for resident #005 on an identified date, and that he and PSW #109 transferred the resident onto the toilet at an identified time. PSW #108 indicated that he was not familiar with the resident, and he obtained information about the resident from his co-worker, PSW #109, who was more familiar with the resident. PSW #108 indicated that he was told by PSW #109 that the resident would use the call bell to call for assistance when the resident was done on the toilet. PSW #108 indicated that he gave the resident the call bell before he left the resident's washroom to assist other residents. PSW #108 indicated that resident #005 never did ring for assistance, and PSW #108 simply forgot that the resident remained in the washroom. PSW #108 indicated that he was unaware that resident #005's plan of care directed that the resident was not to be left unattended on the toilet. PSW #108 indicated that there was a care plan book available on the unit, but when he needed information about an unfamiliar resident's needs, he normally took direction from other more experienced PSWs.

During an interview with inspector #178 on June 14, 2017, PSW #109 indicated that she assisted PSW #108 to transfer resident #005 onto the toilet on an identified date. PSW #109 indicated that she was familiar with resident #005, and she told PSW #108 that resident #005 could be left unattended on the toilet and that the resident likes his/her privacy and would ring for assistance when finished on the toilet. PSW #109 indicated that she told PSW #108 that he should keep an eye on the resident. PSW #109 indicated to Inspector #178 that the staff regularly leaves resident #005 unattended on the toilet, and she was not aware that resident #005's plan of care directed that the resident is not to be left unattended on the toilet. Further, PSW #109 indicated that she is uncertain of how to access the plan of care for a resident, and would obtain information

about a resident's needs by asking other PSWs.

During an interview with inspector #178 on June 15, 2017, the Director of Care (DOC) indicated that resident #005 should not have been left unattended on the toilet, and that this was indicated in the resident's plan of care in place at the time of the incident. Further, the DOC indicated that PSWs can obtain information regarding a resident's care needs from the resident's plan of care, which they access through Point of Care, the PSW's computerized documentation system.

(008174-17) [s. 6. (7)]

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 the care set out in the plan of care is provided to resident #005 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Review of an identified Critical Incident Report (CIR) indicated that on an identified date, resident #003 witnessed resident #001 touch resident #002 inappropriately. Resident #003 alerted PSW #105, who moved resident #002 to a safe place. Resident #003 informed a family member of the incident, who informed the home of the incident two

days later. Video camera footage was reviewed by the home, and the footage confirmed resident #003's report.

During an interview with Inspector #178 on Jun 9, 2017, resident #003 indicated that he/she did witness resident #001 touching resident #002 inappropriately on one occasion, and resident #003 called a staff member who removed resident #002 from the area. Resident #003 indicated that he/she told a family member about the incident, and the family member called the home to report the incident. The home notified the police, and they came to the home to investigate.

During an interview with inspector #178 on June 9, 2017, PSW #105 indicated that on an identified date, resident #003 called to her to alert her that resident #001 was touching resident #002 inappropriately. PSW #105 indicated that she moved resident #002 to a safe location away from resident #001, and reported the incident to her coworkers, including the RPN #100, who was in charge of the unit at the time. PSW #105 indicated that the incident as reported by resident #003, would be considered sexual abuse of resident #002.

During an interview with Inspector #178 on June 8, 2017, RPN #100 indicated that he was not informed of the inappropriate touching incident by PSW #105, and that he was made aware of the incident when resident #003's family member called the home to report the incident.

During an interview with Inspector #178 on June 12, 2017, the DOC indicated that the home's management was first made aware of the alleged abuse incident two days after the incident took place, when resident #003's family member called the home to report it. At that time the home initiated an investigation and reported the alleged abuse to the Director under the Long-Term Care Homes Act (LTCHA). The DOC indicated that PSW #105 failed to follow the home's Non Abuse policy because she did not immediately report the incident to the home's charge nurse, the clinical manager, or the DOC.

Inspector #178 reviewed the home's policy, Mandatory Reporting of Resident Abuse or Neglect, #ADMIN-010.01, effective August 31, 2016, which states that anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.

(009155-17) [s. 20. (1)]

2. Review of an identified Critical Incident Report (CIR) indicated that while being provided care on an identified date, resident #004 alleged that PSW #105 hit the resident. When a second PSW intervened and asked the resident where the resident had been hit, the resident then indicated that PSW #105 had not hit him/her, but had shaken his/her arm. The CIR indicated that PSW #105 reported the allegation to RPN #103, but that RPN #103 failed to follow the home's policy that promotes zero tolerance of abuse and neglect of residents by not reporting the incident to the nurse in charge.

During an interview with Inspector #178 on June 8, 2017, RPN #103 indicated that on an identified date, PSW #105 told her that as she was providing care to resident #004, the resident suddenly said to her "don't hit me", but PSW #105 denied hitting the resident. RPN #103 indicated that because the resident had a history of making unfounded allegations, RPN #103 did not report the allegation to the charge nurse. RPN #103 documented the allegation in resident #004's progress notes.

During an interview with Inspector #178 on June 9, 2017, PSW #105 indicated that on an identified date, while she was providing care to resident #004, the resident became upset and began shouting at her "don't hit me". PSW #105 indicated that she quickly left the room and informed RPN #103, while another PSW completed resident #004's care.

During an interview with Inspector #178 on June 12, 2017, the DOC indicated that RPN #103 failed to follow the home's Non Abuse policy because she did not immediately report resident #004's abuse allegation to the home's charge nurse, the clinical manager, or the DOC. The DOC indicated that RPN #103 received a written warning for failing to report the abuse allegation as per the home's Non Abuse policy.

Inspector #178 reviewed the home's policy, Mandatory Reporting of Resident Abuse or Neglect, #ADMIN-010.01, effective August 31, 2016, which states that anyone who becomes aware of or suspects abuse or neglect of a resident must immediately report that information to the Executive Director, or if unavailable, to the most senior supervisor on shift.

(002771-17) [s. 20. (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 the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 22nd day of June, 2017

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

Original report signed by the inspector.