Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2018	2018_682549_0004	001697-18, 001708-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

RENA BOWEN (549)

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 29, 30 31, February 1, 2, 5, 8, 2018.

Log # 001697-18 related to an injury to a resident for which the resident was taken to hospital, was also inspected.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Clinical Care Manager (CCM), the Director of Care (DOC), the Assistant Executive Director, the Executive Director and the Regional Manager of Clinical Services.

The inspector also observed the provision of care, reviewed residents health care records, the licensee's investigation documentation, Least Restraint Program CARE10-O10.01 policy and procedures, restraint documentation and staffing schedules.

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

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

3 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. (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 resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan is no longer necessary.

A Critical Incident Report (CIR) was submitted by the licensee to the Ministry of Health and Long Term Care on a specific date in 2018, indicating that resident #001 sustained an injury of unknown cause and was admitted to the hospital.

Resident #001’s progress notes indicate that the resident was admitted to the hospital with fractures on a specific date in 2018. The resident returned to the home on on a specific date in 2018

The resident’s progress notes also indicate that resident #001 was admitted to the home on a specific date in 2011 with multiple diagnoses.

Review of the resident’s current written plan of care last reviewed on a specific date in 2017 indicated that the resident is to be in a tilt wheelchair for safety and a specific restraint is to be applied as a fall prevention strategy. The resident has a history of falls, impaired judgement, poor balance and gait, poor posture and rigidity, unable to ambulate long distance. The resident does not have the insight or judgement to call for assistance. Tilt recliner wheelchair for comfort and positioning due to cognitive impairment attempting to get out of wheelchair. Check every two hours and reposition.

Resident #001’s fall assessment was completed by the physiotherapist on a specific date in 2018. The assessment indicated that the resident remains at high risk for falls due to tendency to get up on own and the resident’s impaired cognition.

On January 29 and 30, 2018, Inspector #549 observed resident #001 sitting in a tilt wheelchair with a restraint applied. The tilt on the wheelchair was not in an engaged tilt position during either observations. The resident was unable to undo the restraint when requested by the inspector on either day.

The resident’s progress notes indicated that the resident’s own tilt wheelchair was removed on a specific date in 2018, the tilt wheelchair was assessed as being unsafe by the physiotherapist. Also on the same specific date in 2018 a different tilt wheelchair was

provided to the resident with a different restraint until the resident's new tilt wheelchair could be delivered. Resident #001 no longer had the type of restraint that was on the resident's own tilt wheelchair.

A such, resident #001's plan of care was not reviewed and revised when the resident was reassessed on a specific date in 2018 and a different wheelchair was provided to the resident with different type of restraint. [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 resident #001 is reassessed and the plan of care reviewed and revised 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. the person who applied the device and the time of application; 6. all assessments, reassessments and monitoring, including the resident's response; 7. every release of the device and all repositioning; 8. and the removal or discontinuance of the device.

In accordance with O. Regulation 79/10, s.110 (2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour in addition to a release and reposition at least every two hours and at least every eight hours the resident's condition is reassessed and the effectiveness of the restraining be evaluated by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff.

1. Resident #002 was observed on January 30 and 31, 2018 by Inspector #549 to have a

restraint applied while seated in a wheelchair. The resident was unable to release the restraint when requested by the inspector on either day.

Inspector #549 reviewed resident #002’s health care record on January 30, 2018. The health care record contained a physician’s order for a restraint to be applied while up in wheelchair. The health care record also contained a consent from the Substitute Decision Maker (SDM) for the restraint. Resident #002’s current plan of care gave direction that the resident was to have a restraint applied when up in wheelchair as a fall prevention intervention.

During an interview with Personal Support Work (PSW) #103 on January 31, 2018, it was indicated to the inspector that the resident is assisted up in the morning and is up in a wheelchair with the restraint applied. PSW #103 indicated that if the resident gets tired the PSWs will assist the resident to bed for a rest in the afternoon. The resident will be assisted back up in the wheelchair if resting and put back in the wheelchair for supper. Registered Practical Nurse (RPN)#101 indicated that resident #002 is usually seated in the wheelchair for most of the day.

2. Resident #003 was observed on January 30 and 31, 2018 seated in a wheelchair with a restraint applied. The resident was unable to release the lap belt when requested by the inspector on either day.

Inspector #549 reviewed resident #003’s health care record on January 30, 2018. The health care records contained a physician’s order for a restraint to be applied while up in wheelchair. The health care record also contained a consent from the SDM for the restraint. Resident #003’s current plan of care gave direction to apply the restraint when in wheelchair as a fall prevention intervention.

RPN #102 indicated during an interview on January 30, 2018 that resident #003 has not been well for the last few weeks and spends more time in bed than usual.

During an interview on January 30, 2018, RPN #102 indicated to the inspector that the PSWs are responsible for the documentation related to restraints. RPN #102 stated that the restraint documentation is completed by the PSWs in Point Click Care (PCC).

During an interview with PSW #106 on January 30, 2018 it was indicate to the inspector that all applications and all releases of the restraint, monitoring and repositioning of the resident is completed in PCC by the assigned PSW.

During an interview on February 1, 2018, CCM #100 stated that the resident's condition is reassessed and the effectiveness of the restraining evaluated every eight hours by the registered staff. CCM#100 also stated during the interview that the documentation could be found in the resident's Medication Administration Records (MARS).

Inspector #549 reviewed the restraint documentation in PCC for a specific time period in 2018 for resident #002 and resident #003. The restraint documentation did not include the application or release of resident #002's or resident #003's restraint. The documentation did not include the two hour repositioning of the resident or the hourly monitoring of the resident while the restraint was applied for the specified time period.

Inspector #549 reviewed the MARs for resident #002 and resident #003 for a specific time period in January 2018. Resident #002's MARs included a section that stated "Resident Safety Review (Nurse) Wireless alarm monitoring, Fall Risk Restraint, Behaviours". There is a section for the registered staff's electronic signature on all three shifts. The documentation did not include the assessment of resident #002's condition and the effectiveness of the restraining for the specified time period.

Resident #003's MARs also did not include any documentation by the registered staff related to the assessment of the resident's condition or the effectiveness of the restraining for the month of January 2018.

During an interview on February 1, 2018, the Director of Care (DOC) stated that the restraint documentation for resident #002 and resident #003 did not include every application and release of the restraint, the hourly monitoring and repositioning of the resident. During the same interview the DOC also stated that the restraint documentation did not include the assessment of the resident's condition and the effectiveness of the restraining every eight hours by a registered staff member.

As such, the licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application; all assessments, reassessments and monitoring, including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. [s. 110. (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 following is documented related to the physical restraining of a resident. The person who applied the device and the time of application, all assessments, reassessments and monitoring , including the resident's response, every release of the device and all repositioning and the removal or discontinuance of the device, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #001 was hospitalized on specific date in 2018 and remained in hospital until a specific date in 2018 at which time the resident was re-admitted back to the home.

Inspector #549 observed the resident sitting in a tilt wheelchair with a restraint applied on January 29 and 30, 2018.

During an interview on January 29, 2018, Clinical Care Manager (CCM) #100 stated that resident #001 should have a restraint applied as the resident was assessed as a high risk for falls. The CCM#100 also stated that the resident has a history of falls resulting in injuries and hospitalizations.

Inspector #549 reviewed resident #001's health care file, the resident's readmission orders dated a specific date in 2018. Inspector #549 was unable to locate on the readmission orders or any other order following hospitalization an order for the use of a restraint.

During an interview on January 30, 2018, CCM #100 said that all previous orders are automatically discontinued when a resident is admitted to hospital and readmission orders are received from the home's physician when a resident is readmitted back to the home. CCM #100 also said that the readmission orders for resident #001 should have included an order for the restraint when the resident was readmitted to the home on a specific date in 2018.

As such, the licensee failed to include in resident #001's restraint plan of care an order for a restraint by a physician or a nurse of the extended class. [s. 31. (2) 4.]

Issued on this 13th day of February, 2018

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

Original report signed by the inspector.