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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2018	2018_617148_0006	020916-17, 022524-17, 023408-17, 004177-18	Critical Incident System

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

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): March 5, 6, 7, 8 and 9 2018

This inspection included four critical incident reports, Logs 022524-17, 023408-17, 020916-17 and 004177-18; each related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director, Assistant Executive Director, Director of Care (DOC), Clinical Managers, Nursing Scheduler, Physiotherapist (PT), Physiotherapy Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition, the Inspector reviewed documents and electronic records as part of the resident health care record and documents related to the licensee's investigation into the identified alleged incidents of abuse. The Inspector also observed the resident's care environment, the resident care and services provided and staff to resident interactions.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

As it relates to a critical incident report, on a specified date, PSW #103 conducted a transfer of resident #002 from the resident's wheelchair to the toilet. During the transfer the foot rests remained attached to the wheelchair and were facing the front; the same position as they would be when in use. The foot plates, whereby the resident would normally place each foot, were flipped upward. The resident expressed the need to remove the entire component of the foot rests prior to entering the bathroom, however this was not done. PSW #103 continued with the transfer with the foot rest forward facing and the foot plates flipped up. During the transfer the resident sustained a minor injury.

In discussion with Clinical Manager #106, who was involved in the licensee's investigation into this incident, and PT #108, the appropriate positioning of the foot rests includes: folding them outward to the side of the wheelchair, folding them inward under the seat or removal of the foot petals. Both staff #106 and #108 reported that the position of the foot rests straight ahead is not appropriate during transfers to and from the wheelchair; regardless of the position of the foot plates.

In this way, on the identified date, the foot rests were not in a position to ensure the safe transfer of resident #002, who sustained a minor injury during the identified transfer. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #2: 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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

As it relates to a critical incident report, on a specified date, resident #003 reported to RPN #114 concerns related to PSW #107 having been rough during bathing care earlier that morning. The licensee conducted an immediate investigation, which concluded that no abuse had occurred. In response to the allegation of roughness the plan of care for bathing for resident #003 was revised to include two staff to assist at all times; this plan of care remains in effect at the time of this inspection.

The regular bath person for this floor, PSW #112, reported to the Inspector that resident #003 requires one person for bathing. Documentation maintained by PSW staff regarding bathing provision was reviewed and it was observed that bathing was recorded as provided by one staff person.

In this way, the plan of care as set out to provide two person assist during bathing was not provided to resident #003 as specified by the plan. [s. 6. (7)]

Issued on this 12th day of March, 2018

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

Original report signed by the inspector.