Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 13, 2020	2019_618211_0026	022273-19	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

JOELLE TAILLEFER (211)

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): December 2, 3, 4, 9, 11, 13, 17, 18, 2019.

This complaint inspection (Log # 022273-19) was related to responsive behaviors, skin and wound care and resident care.

During the course of the inspection, the inspector(s) spoke with The Executive Director, Director of Care (DOC), Associate Director of Cares (ADOCs), Registered Nurses (RNs), a Behavioral Support Worker (BSO), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), the resident, an identified individual and a family member.

During the inspection, the inspector also reviewed the resident's health care records (including care plans, progress notes, flow sheets, skin and wound evaluations, Responsive Behaviors Huddles, physiotherapy assessment, specialized resources sheets, referrals and medication administration records) personal care schedules sheets, a letter, emails, investigation notes, staff schedules and education and training attendance forms.
In addition, the inspector reviewed the skin and wound care, responsive behavior and resident non-abuse policies; as well as observed the provision of care, services to residents and resident home care environments.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours
Skin and Wound Care

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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Interview with the DOC on an identified date, stated that a specific method was created, started and placed in resident #001’s room to facilitate the communication between the staff and the family. The nursing staff requirements were to use the specific method when the personal care was completed during the two specific shifts.

Review of resident #001's specific method for nine identified consecutive dates, included six identified personal cares to be provided and an area for the nursing staff to put their initial. On an identified date from a specific shift, a section was incorporated into the

identified method that included one identified personal care and an area for an initial. Then, another identified task was included fourteen days later for a specific shift.

Review of the resident's current plan of care did not provide instruction to the nursing staff to complete the identified method placed in a specific item in the resident's room during the two identified shifts.

Interview with ADOC #103 on an identified date, stated that the identified task method was placed in the resident's room inside a specific item for the PSW to complete after the resident's care was provided. ADOC #103 acknowledged that the identified task method was not completed nor signed by the PSW on three identified dates, during a specific shift and two other dates, during another shift, as previously discussed with the resident's SDM to facilitate the communication between the staff and the family.

The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provide direct care to the resident that a specific item with the identified task method placed in the resident's room needed to be complete during two specific shifts. Consequently, the identified task method was not completed by the PSWs for the above shifts. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other
(b) in the implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

In an interview with PSW #127 on an identified date, stated not being informed that resident #001 had specific responsive behaviors and that an identified task method was kept in the resident's room to be completed. Moreover, PSW #127 stated not viewing the resident's plan of care before starting the resident's personal care prior the shift of the identified date. The only information received by PSW #126 prior resident #001's personal care at the beginning of the shift was that resident required assistance of two staff for personal care and when it was time, they would go together. PSW #127 stated that resident #001 was calm during care at a earlier identified time with the assistance of the second PSW. However, the resident demonstrated the identified responsive behavior at a later hour when care was provided by two PSWs and while an identified person was in the room. Furthermore, PSW #127 validated not being aware that the identified method was placed in the resident's room and needed to be completed until the identified person asked at a specific time, if it was completed earlier.

The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the implementation of resident #001's plan of care so that the different aspects of care are integrated and are consistent with and complement each other for the following reasons when PSW #127:
1. didn't read the resident's plan of care prior giving care to the resident,
2. was not informed by the other nursing staff member that the resident may exhibit responsive behaviors during care, and
3. that an identified method kept in a specific item in the resident's room needed to be completed during the identified shift. [s. 6. (4) (b)]

3. In an interview with resident #001's SDM on an identified date, stated that PSWs #110 and #109 transferred the resident in bed later than a specific time. The SDM communicated that resident #001's responsive behaviors were aggravated when resident 's care was provided without certain identified techniques or after a specific time.

In an interview with PSW #109 on an identified date, stated being told by a staff to provide resident #001's personal care after a specific unit practice during an identified shift and not being told to be in the room exactly at a specific time. PSW #109 indicated entering resident #001's room fifteen minutes late and PSW #110 was not yet in the room.

In an interview with RN #113 on an identified date, indicated after PSW #109 finished carrying out the identified unit practice for the residents in the unit, PSW #109 didn't know that PSW #110 was waiting in resident #001's room to start the resident's care at approximately at a specific time. The resident's personal care was started late since both PSWs didn't communicated clearly when to start the resident's care. Furthermore, RN #113 stated being told by RPN #114 that during the beginning of the identified shift report, RPN #114 tried to explain to the nursing staff members the special requirements necessary to care for resident #001, but the staff were not listening and PSW #109 replied being aware of resident #001's plan of care. RN #113 stated if PSW #109 would have listen when RPN #114 was trying to give specific instructions related to resident #001's personal care during the shift report, it would have prevented this issue.

The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the implementation of resident #001's plan of care so that the different aspects of care are integrated and are consistent with and complement each other for resident #001's personal care during the identified shift.

[s. 6. (4) (b)]

4. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Review of resident #001's MAR for sixteen consecutive identified dates, indicated to check if PSW had signed the specific task item in the resident's room at a specific time. Review of resident #001's MAR from a later identified date, indicated to check if PSW has signed the specific task item in resident's room every day for two specific shifts. However, there was no information in the MARs for seventeen consecutive identified dates, indicating to check if PSW had signed the specific task item in the resident's room.

Interview with the ADOC #103 on an identified date, stated that the registered nursing staff responsibility was to verify daily that the PSWs had completed the identified task item. ADOC #103 confirmed that the registered nursing staff members didn't ensure that the identified task item was completed by the PSWs on three identified dates on specific shifts, as previously discussed with the SDM.

The licensee has failed to ensure that the care set out in the plan of care was verified by the registered nursing staff members that the identified task item was completed by the PSWs as specified in resident #001's MAR for the above shifts. [s. 6. (7)]

5. In an interview with resident #001's SDM on an identified date, stated that PSW #110 exhibit a specific behavior while providing resident's personal care.

Review of resident #001's last current plan of care, indicated that one of the interventions was that the resident required a quiet place free of distraction when completing tasks.

In an interview with PSW #110 on an identified date, stated that a person was upset because they were late to transfer the resident. PSW #110 stated exhibiting a specific behavior toward the identified person and confirmed that this behavior was not appropriate while providing care to the resident.

The licensee has failed to ensure that the care set out in the plan of care that indicated the resident required a quiet place free of distraction when completing tasks was provided to resident #001 as specified in the plan when PSW #110 exhibit a specific behavior toward an identified person. [s. 6. (7)]

6. Review of resident #001’s last current plan of care, indicated that one of the interventions was that the resident required a quiet place free of distraction when completing tasks.

Review of resident #001’s progress notes written by RN # 121 on an identified date, indicated that the staffs were reminded to provide resident's intervention on time and with specific approaches in front of the resident or the other individual when providing care to the resident.

In an interview with RN #121 on an identified date, stated being reported that one of the PSW started giving resident #001’s personal care at a specific time without the second PSW that was assigned to help. When the second PSW arrived in the resident’s room an argument started between the two PSWs. RN #121 indicated that the PSWs didn’t follow the resident plan of care when they started arguing with each other in front of the resident since the resident requires a quiet environment free of distraction when providing care as these could increase the resident’s identified responsive behaviors. [s. 6. (7)]

7. The licensee has failed to ensure that the provision of the care set out in the plan of care are documented.

In an interview with ADOC #103 on an identified date and review of resident #001’s health care records, including the Point of Care (POC) electronic documentation didn't indicate if the resident’s bath was given on two identified dates.

The licensee has failed to ensure that resident #001’s bath was documented for those two identified dates. [s. 6. (9) 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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident,
-to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
-to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and
-to ensure that the provision of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care must be based on, at a minimum, interdisciplinary assessment of the sleep patterns and preferences.

In an interview with resident #001's substitute decision maker (SDM) on an identified date, stated that the resident needed to be transferred in bed at a specific time for a rest period and at bedtime.

Review of resident #001's last Care Plan, did not provide the resident's sleep patterns and preferences, including the rest period.

In an interview with RN #113 on an identified date, stated that resident #001's sleep patterns and preferences were not included in the resident's plan of care nor in other health care records.

In an interview with the Executive Director and the DOC on an identified date, acknowledged that resident #001's plan of care should indicate the preference of the resident's sleep and rest period patterns. However, resident #001's sleep and rest periods may not be provided exactly at these specified time should an unforeseen event or an emergency arise.

The licensee has failed to ensure that resident #001's plan of care included the interdisciplinary assessment of the resident's sleep patterns and preferences, including the rest period. [s. 26. (3) 21.]

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's plan of care must be based on, at a minimum, interdisciplinary assessment of the sleep patterns and preferences, to be implemented voluntarily.

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.