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 prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 6, 7, 14, 2012	2012_034117_0011	Critical Incident

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Regional Director of Client Services, a Clinical Care Manager, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers (PSW), to a dietary aid, the home's Food Service Manager, to several administrative staff and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of two identified residents; reviewed two critical incident reports; examined a resident care unit elevator security alarm system; examined a resident care unit floor stairwell security system; examined an identified resident's wanderguard bracelet; reviewed the front door entrance security alarm system and observed a lunch time meal service on March 6, 2012.

It is noted that two critical incident inspections were conducted during the course of this inspection : Log # O-001332-11 and # O-002282-11.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with the LTCHA section 3 (1) (1) in that an identified resident was not treated with courtesy and respect and in a way that fully recognizes their individuality on a specified day in June 2011 by an identified PSW.

During the breakfast meal service of a specified day in June, 2011, the identified resident was having breakfast at an assigned dining table, in the unit dining room. The identified resident was reaching for another resident's food. The identified PSW, who was seated at the same table and assisting another resident with their meal, slapped the identified resident's hand. The resident was upset and told the PSW not to slap him/her again. The PSW denied having slapped the identified resident's hand.

The interviewed unit RN states that he/she was present in the unit dining room on the specified day in June, 2011. The RN states that he/she witnessed the PSW slapping and then denying having slapped the identified resident's hand. The resident's hand was assessed by the unit RN and it was noted to be red and slightly swollen.

The RN states that he/she immediately reported the incident to the home's Administrator.

The Administrator states that the PSW was immediately removed from work. The Administrator states that an investigation was initiated and the PSW received disciplinary sanctions as per home's internal policies . The incident was reported to the Director. [Log # O-001332-11]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA section 5 as it relates to ensuring the safety and security of an identified resident on a specified day in October, 2011, when the resident was missing from the long-term care home for a period greater then 6 hours.

The identified resident has cognitive impairments and is known to be an active wanderer within the home. The resident resides on one of the home's secure units. He/ She also wears a wanderguard bracelet to ensure his/her safety and security on the unit and in the home.

On the evening of the specified day in October, 2011, around 18:30 hrs, the identified resident was observed by nursing staff and a dietary aide staff to be wandering the unit hallways. The resident was seen to wear his/her coat and to tell other residents he/she was going home. The resident was observed to try to push open the locked stairwell doors. An interviewed PSW states that the resident was redirected away from the stairwells but kept pacing hallways, expressing his/her wish to go home.

The PSW states that the resident was seen a few minutes later by themself and the dietary aide close to the elevators. Two other residents were also present, seated close to the elevator doors. The PSW states that he/she went and assisted another resident. The PSW states that a few minutes later the dietary aide, who was in the unit kitchen servery, heard the elevator alarm go off. When the dietary aid arrived at the elevators, the elevator doors were closed, and only two residents were seated close to the elevator doors. The identified resident was not seen.

The PSW states that the dietary aide immediately notified the unit RN of the elevator alarm being activated and that the identified resident was last seen close to the elevators. The unit RN initiated a search to verify location of resident on the unit. The resident was not found.

Documentation in the resident's health care record indicates that the RN then notified the administration of the resident not being found on the unit. The home initiated a Code Yellow search of the home and its grounds. The identified resident was not located. The local police and the resident's family were notified of the resident's elopement at 19:15hrs. Police search was initiated.

The identified resident was found 5 km away from the home, the next day at approximately 02:00am. The resident was uninjured. The resident's wanderguard bracelet activated the home's front entrance security alarm when he/she returned to the home. The resident was placed under close supervision and monitoring upon his/her return to the home. The resident has not had any other exit seeking behaviours since this incident in October 2011.

The home verified their elevator and door security systems, including wanderguard bracelet security systems. All security systems were functioning at the time of the resident's elopement. The home was unable to determine how the identified resident eloped from their premises. [Log # O-002282-11]

Issued on this 14th day of March, 2012

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