Ontario

Ministry of Health and Long-Term Care

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

Ministére 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
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 24, 25, 27, Aug 1, 2012	2012_030150_0015	Complaint

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Executive Director Assistant, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW) and resident.

During the course of the inspection, the inspector(s) reviewed the resident's health records, the home's Client Services Response Form to complaints and concerns, policies #LTC-P-120-ON Personal Assistive Service Device (PASD) revised March 2012, #:TC-P-125 Restraint Reduction Protocol revised March 2012.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6(1) (c) as the plan of care does not set out clear direction to staff and others who provide direct care to the resident.

An identified resident's progress notes reviewed from March to July 2012, indicate that the resident had a fall in March and May 2012.

The resident's care plan revised in June 2012, indicates that the resident is at high risk of falls secondary to making attempts to do self transfers against the advice. The care plan does not identify the use of a PASD (Personal Assistive Supportive Device) or restraint.

The RAP (resident assessment protocol) of March and June 2012 both indicate that "Falls were triggered and the nature of the problem is the resident is at risks for falls. The resident has a history of falls and had a fall".

RAP - restraint was not triggered for both assessments.

In March 2012 , a consent for PASD seat belt was signed by the POA.
In April 2012, a "restraint consent" for a front-closing seat belt was signed by the POA.

Interviewed RN and RPN, who stated that the resident had on a PASD for safety fall prevention.

During the inspection, the resident was observed sitting in his wheelchair with a front buckle belt in place. The belt was observed to be well positioned.
The resident stated that the belt is there to prevent him from falling . The resident states that he/she has fallen several times and did hit his head at times.

The medication administration records(MAR) in June 2012 indicate the safety belt use and staff where monitoring the application, removal of the safety belt as per documentation.

Plan of care and resident's assessment does not give clear directions to staff as it does not identify the use of the lap belt and it does not identify if it is a restraint or a PASD.

Issued on this 1st day of August, 2012

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