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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2013	2012_193150_0008	2072/0986/2 131/1319/14 33-12	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): December 7, 10, 11, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Regional Manager, Director of Care (DOC), Environment Manager, Clinical Managers, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Receptionist and residents.

During the course of the inspection, the inspector(s) reviewed residents' health care records, policy #HS16-0-12 Safety in ambulating lifting and transferring program revised June 2012, policy #LTC-P-10 Wandering Resident Protocol dated September 2001, front desk list of identified residents at risk for elopement, residents' pictures and assigned wanderguard bracelet number specific for each residents.

During the course of this inspection 5 critical incidents were reviewed:

Log# O-001433-12, O-002131-12, O-000986-12, O-001319-12, O-002072-12.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Reporting and Complaints

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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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. (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. (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 has failed to comply with LTCHA, 2007, c8, s.6 (1) (c) in that the plan of care did not provide clear direction to staff and others who provide direct care to the resident.

On a specific date in May 2012, the progress notes documented by the Registered Practical Nurse indicates resident#1 was assisted back to the floor by staff because the resident was stating I should be at home and was unable to identify the floor and room number. The resident#1 was identified at high risk for elopement, wander guard #156 in place, POA informed and agreeable.

No interventions were documented in the plan of care related to the resident's risk of elopement at that time.

Eight days later, the progress note documentation indicates that the Registered Practical Nurse received a call from resident's family member, who had received a call from the police informing them that the resident was found by the police around the Lincoln Fields area. The resident was sent to the hospital for assessment. The resident returned from the hospital and did not have a wander guard bracelet on. A new wander guard bracelet was applied and 1:1 staff intervention implemented during the night and with every 1/2 hour checks to monitor resident safety.

The resident's care plan updated following the second incident and did identify resident#1 high risk for elopement.

Log #0-001319-12. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c8, s.6 (7) in that the care set out in the plan of care was not provided to the resident as specified in the plan.

On a specific date in September 2012, the resident#3 reported to the Registered Nurse that the Personal Support Worker was rough and bumped the residents' shin against the bed while being transferred to bed overnight. On assessment it was noted that the resident had an injury and pain.

The resident's care plan indicates that the resident requires support of two staff to transfer.

The Director of Care states that during her investigation, the staff member confirmed that the transfer of the resident was done by one staff. A logo was posted above the bed indicating a 2 person transfer.

Log #0-002131-12. [s. 6. (7)]

3. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c8, s.6 (7) in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The clinical manager states that on a specific date in April 2012, she heard the resident#4 calling out to go get a baby down stairs and observed the nurse assisting the resident to remove a jacket and telling the resident to stay on the unit instead of distracting the resident which escalated the resident's agitated behaviour.

The staff states that the resident is known to have agitated behaviours and the plan of care interventions indicates to distract the resident and let the resident go downstairs.

Log #O-000986-12. [s. 6. (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 plan of care provide clear direction to staff and others who provide care to the resident and the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: 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:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c8, s.3 (1) 8 in that a resident's privacy in treatment and in caring was not respected.

On a specific date in April 2012, a staff member witnessed another staff using a cell phone, video taping resident#4 when the resident was agitated and shouting in the hallway.

The administrator investigated, confirmed the incident and ensured that the video tape was destroyed. Disciplinary measures were applied and inservice on unauthorized use of cell phone and code of conduct was given.

Interviewed the resident and the resident did not recall of the incident.

Log #0-000986-12. [s. 3. (1) 8.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c8, s.24 (1) 3 in that a critical incident related to unlawful conduct were not immediately reported to the Director.

On a specific date in August 2012, a staff member informed the home's administration of a suspicion of a staff member of having an unlawful conduct with 2 residents. The administrator states that during there investigation one of the identified resident confirmed the allegation. The other resident had passed away.

The critical incident report of unlawful conduct was submitted to the Director on September 14, 2012. [s. 24. (1) 3.]

Issued on this 11th day of January, 2013

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