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
Jul 16, 2013	2013_193150_0014	O-000533-13	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): June 26, 27, 28, July 2, 3, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director , Director of Care, Executive Assistant, Clinical Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the resident.

During the course of the inspection, the inspector(s) reviewed the resident's health care records, the home's investigation report, the home's Resident Non-Abuse policy #LP-G-20-ON revised March 2013, the home's Mandatory Training Program related to Zero Tolerance of Abuse and Neglect, the home's staff mandatory training participation records for 2012, 2013, specific staffs' criminal reference records checks, Pain Assessment and Symptom Management policy #LTC-E-80 revised August 2012, Skin and Wound care Program #LTC-E-90 revised August 2012, observed staff-resident interactions and the resident's activities.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Critical Incident Response

Medication

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Training and Orientation

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. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s.6.4(a), in that the licensee did not ensure that nursing assessment of the resident's bruised hands was integrated and consistent with and complement each other.

Resident #01 suffers anxiety disorder and dementia. The resident plan of care identifies that the resident requires 1-2 staff assistance for personal care and can be resistive to care. The plan specifies that if the resident refuses care, staff are to re-approach at a later time to provide care and services.

Resident is not identified as having any ongoing pain issues and skin integrity issues. Skin assessment was done on bath records on a specific date and showed resident had no bruises or skin integrity issues.

On a specific date in June 2013, the night RPN S#107 documented that the PSW S#106 called the RPN S#107 to check resident #01 hands. The RPN #S107 observed that the resident #01 had bruising and swelling the hands. "When the PSW S#106 touch the resident's hands, the resident withdrew them and said it hurts, the resident became agitated". "The RPN S#107 reported the incident to the day shift nurse at change of shift to continue monitor resident's hands".

On a specific date in June 2013, the day RPN, documented in the progress notes that "the resident had bruises on the hands, offer to applied ice and resident refused stated I don't have anything wrong with my hands". "POA inform of the bruises on her hands, not aware where they come from, internal incident report file, charge nurse aware".
June 16, 2013, evening RPN documented, "hand remains swollen, ice pack applied."

On a specific date in 2013, the night RPN documented on the night shift report, "resident was put into bed, increase agitation medication given with effect."

On a specific date in 2013, day RPN documented "report from night shift regarding bruise on residents hands, resident stated very painful. Notified Clinical Manager".

On a specific date in 2013, documented "the clinical manager S#103 was requested to access resident' hands for bruising that was noted."
It was noted that the resident hands were bruised. The resident was unable to lift her hand over to show the manager and stated it was very painful.

The resident did refuse to take her medication for pain. The DOC S#102 came to assess, called the physician and the police. The physician came to assess and ordered to transfer resident out to have x-ray done of both hands. Some pictures were taken of the bruising and swelling of hands. The police arrived and took the report." Resident transferred to hospital.

On a specific date in June 2013, documented " hospital physician confirmed that x-ray results of broken bones, plan was to splint them."

On a specific date in June 2013, critical incident report submitted to MOH.

During the inspection, interviewed RPN S#111 and RN S#117, and they stated that they did a visual assessment of the back of the resident's hands but did not examine the palm and side of the hands because the resident was resistive and refusing to be further touched. The RPN and RN did indicate that the resident is known to use her hands to push the staff when she was resistive to care.

The RN S#117 stated that on a specific date in June 2013 on the evening shift she attempted twice to assess further but was unsuccessful because the resident was refusing to be touched.

During the inspection the inspector #150 interviewed the 3 RN Charge Nurse S#116, S#117, S#118 covering day, evening and night shifts on the a specific dates in June 2013. Based on the interviews, the 3 charge nurses said that the RPN are responsible to do their assessment and if they have concerns they call the RN to come and assess.

The 3 charge nurses stated that they were informed of the resident's bruise hands during the rounds and shift report. They confirmed that they were not asked to do a further assessment.

June 26, 2013, the inspector #150, interviewed the manager S#101 on call and the DOC S#102 for the specific dates in June 2013. They both confirmed that the manager and back-up nursing manager on call were not inform of the resident's bruising of both hands incident on specific dates in June 2013. [s. 6. (4) (a)]

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 nursing assessment of the resident's bruises and pain is integrated and consistent with and complement each other., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 52 (2) in that the pain assessment instrument specifically designed for this purpose was not use on June 16 and 17, 2013.

On specific date in June 2013, the day RPN, documented that "the resident had bruises in both hands and offer to applied ice and resident refused stated I don't have anything wrong with my hands".

On specific date in June 2013, evening RPN documented, "the resident refusing to go to bed or receive HS care. Left hand left index finger remains swollen, ice pack applied."

On specific date in June 2013, the night RPN documented on the night shift report ," resident was put into bed , increase agitation medication given with effect ."

On specific date in June 2013, day RPN documented "report from night shift regarding bruise on residents hands and looks bluish color and swollen, resident stated very painful, would not let the RPN touch."

On specific dates in 2013 documented on MAR sheet that the resident was administered her regular pain medication twice a day.

On specific date in June 2013, documented " hospital physician confirmed that x-ray results of broken bones,on the hands, plan was to splint them."

On specific date in June 2013, the PAINAD – pain assessment in advanced dementia was started with a PAINAD score of 9/10.

On specific date in June 2013 documented "that a splint was applied to hand, the hands remained swollen and the resident denies any pain. Pain assessment flow sheet started pain medication administered for comfort. Facial grimacing noted and resident yelling out when care is being given, Diet and fluid intake very poor intake and output record started. Dr. contacted, new orders received.

The Licensee's pain assessment and symptoms management policy #LTC-E-80 revised August 2012 indicates that if the resident complains of pain, a quick pain assessment on the Resident will be completed using PQRST and documented.

No pain assessment tool was use on specific dates in June 2013 to assess the resident's pain. [s. 52. (2)]

Issued on this 22nd day of July, 2013

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