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

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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
Dec 10, 2013	2013_225126_0034	0-000403,511, 1132-13	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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 26, 27, 28, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Assistant Executive Director, the Director of Care, two Care Coordinators, the Environmental Manager, several Registered Nurses, several Registered Practical nurses, several Personal Support Workers, family members and several residents.

During the course of the inspection, the inspector(s) reviewed several health care records, the temperature chart on the unit, observed care and services given to residents.

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

Responsive Behaviours

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.53. (4) (a) in that the home did not ensure that the behavioural triggers are identified for Resident #2's responsive behavior.

Resident #2 health care record was reviewed. Resident #2 exhibited several responsive behaviors on specified day in October and November 2013. No interventions are documented in the plan of care to manage these responsive behaviors.

Discussion with Day Shift Registered Practical Nurse and with the Evening Shift Registered Nurse who indicated that Resident #2 does have responsive behaviors. They also indicated that Resident #2 is on anxiolitic medication if needed but they have not been administering this medication.

Discussion with two Personal Support Workers (PSW) who indicated that Resident #2 does have responsive behaviors at time when care is provided. Care is provided to Resident #2 with two PSWs at a time.

Resident #1 and Resident #2 are sharing a room. Resident #1 indicated that often he cannot sleep because of Resident #2 behaviors.

No behavioral triggers interventions are documented in the plan of care to effectively manage Resident #2 responsive behaviors. [s. 53. (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 the behavioral triggers are identified to effectively manage Resident #2 behaviors., to be implemented voluntarily.

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Issued on this 10th day of December, 2013

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