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
Mar 26, 2014	2014_304133_0007	O-000028-14	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

JESSICA LAPENSEE (133), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4th - 6th, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Clinical Coordinator, the Environmental Services Manager, Physiotherapy staff, Registered and Non-Registered Nursing staff and Housekeeping staff.

During the course of the inspection, the inspector(s) reviewed the health care record of a former resident and observed washrooms, bedrooms and common areas throughout the home with a focus on cleanliness.

The following Inspection Protocols were used during this inspection:

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Accommodation Services - Housekeeping
Infection Prevention and Control
Personal Support Services

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O 2007, c.8, s.15 (2) a. in that the licensee has failed to ensure that equipment, such as toilets and raised toilet seats, and surfaces, such as walls, in identified resident washrooms are being kept clean and sanitary.

The licensee has a history of non-compliance with LTCHA, 2007, S.O 2007, c.8, s.15 (2) a. As a result of inspection # 2012_204133_0006, conducted November 21st – 23rd, 2012, the licensee was issued a Written Notification and a Voluntary Plan of Correction, pursuant to this section, on November 28th, 2012.

Areas of concern, described below, were revisited by the inspector over a 2 day period, March 4th and 5th, 2014. These areas of concern were shown to the home's Environmental Services Manager on the last day of the inspection, March 6th, 2014.

The following observations, made in washrooms shared by 2, 3 or 4 residents, present a pattern of non-compliance, with potential risk to residents related to infection prevention and control.

Room #227 – The lower washroom wall next to the toilet, and all around to the lower inner washroom door, was dirty with spots of dried dark brown matter. The lower right side of the outer toilet bowl was dirty with a patch of dried fecal matter with streaks of dried fecal matter around it.

Room # 230 – The lower area of one side of the raised arms on the toilet was dirty with dried light coloured crusty matter.

Room # 332 – The washroom wall, next to the toilet, was dirty with dried brown spots.

Room # 330 – The lower inner washroom door was dirty with dried brown spots.

Room # 326 – The lower inner washroom door, directly across from the toilet, was dirty with brown areas that the inspector could wipe away with a piece of wet paper towel. The toilet was dirty with light brown spots, on the back of the toilet seat lid, on the toilet seat, within the upper portion of the inner toilet bowl, and on the outer upper toilet bowl. The underside of the toilet seat was very dirty with dried brown spots. Spots of dried brown matter were noted on the back portion of the raised arm on the toilet, as well as on the wall behind the toilet, and the lower inner door behind the toilet.

Room #301 – The mid to lower inner washroom door frame was dirty with dried brown matter, as was the wall just above the garbage can. The upper outer toilet bowl was dirty with dried brown and yellow matter. The underside of the toilet seat was heavily soiled, with dried brown and yellow/orange matter.

Room #525 – The underside of the front horizontal bar of the raised toilet seat was dirty with dried fecal matter, and the upper side of the outer toilet bowl was dirty with dried fecal matter. This bedroom was empty at the time of the inspection, and it had been cleaned and prepared for re occupancy.

Room #528 – The wall behind the toilet, the wall beneath the towel hooks, and the wall beneath the paper towel dispenser, was dirty with dried light brown spots.

Room #828 – The entire underside of the raised toilet seat was heavily soiled, with dried matter of various colours.

Room #728 – Washroom walls and lower inner washroom door were dirty with light coloured dried matter and dried brown spots.

Room #730 – Washroom wall under sink was dirty with dried brown matter. There was dried brown matter on the back of the toilet seat.

Room # 732 – On the washroom wall, to the left of the call bell console, there was a patch of dried fecal matter.

Room #328 – The washroom wall next to the toilet was dirty with dried, light coloured, crusty matter. [s. 15. (2) (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 with the requirement that the home, furnishings and equipment are kept clean and sanitary, specifically related to equipment and surfaces within shared washrooms, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.229 (4) in that the licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

The licensee has a history of non-compliance with O. Reg. 79/10, s.229 (4). As a result of inspection # 2012_204133_0006, conducted November 21st – 23rd, 2012, the licensee was issued a Written Notification and a Voluntary Plan of Correction, pursuant to this section, on November 28th, 2012.

Areas of concern, described below, were revisited by the inspector throughout the inspection, March 4th -6th, 2014.

The following observations, made in washrooms shared by 2, 3 or 4 residents, present a pattern of non-compliance, with potential risk to residents related to infection prevention and control.

Room # 225 – There were 3 stacked urine collection hats (UCH) on the floor, under the sink. The top UCH was dirty with dried urine, and the UCH below it was dirty with dried brown matter.

Room #229 – Within a green wash basin, on top of the toilet, there was a UHC that

was dirty with dried urine.

Room # 526 – Under the sink, on the floor, there was a blue washbasin, on top of a UCH that was dirty with dried urine and some debris. The dirty UHC was within another blue washbasin.

Room #528:
– On the floor, there was a raised toilet seat, dirty with dust, hair and dried yellow areas, with a white bin on top of it, which was dirty with dust and debris, with a UHC within the dirty white bin, which was also dirty with dust and debris. The underside of the raised toilet seat was heavily soiled, with dried crusty areas, yellow, orange and dark beige in colour.

- On the washroom sink counter, there was a clear plastic bag, containing heavily used razors, and some toothbrushes, none of which were labelled with a resident's name.

Room #527 – On an identified resident's towel bar in the washroom, there was a UCH that was dirty with pieces of dead insect carcases. On the floor, beneath the sink, was a pink washbasin that was dirty with pieces of dead insect carcasses. The washbasin on the floor was labelled with a resident's name.

Room #532 – In the washroom, on the sink counter, there were 5 used toothbrushes, all without name labels, as well as unlabelled brushes and combs.

Room #828 – Hanging on an identified resident's hook, on the inner washroom door, was a cloth urinal storage bag that was dirty with dried yellow matter and extensively stained.

Room #701 – On the washroom sink counter, there was a blue and a grey plastic storage bin. The blue bin was dirty with hair, debris and residue. In the blue bin, there was a white toothbrush in a red plastic cup. The cup was dirty with accumulated dried toothpaste and hair. The toothbrush was not labelled with a residents' name, nor was the blue storage bin. In the grey bin, there was an identical white toothbrush. Neither the grey storage bin, or the white toothbrush within, was labelled with a resident's name.

Room #725 – On the washroom sink counter, was a heavily used razor with no name

on it. In the pink bin on top of the white drawers, across from the toilet, were many heavily used razors, and combs, with no name on them.

Room # 727 – On the washroom sink counter, behind the taps, was a white plastic toothbrush that was not labelled with a resident's name. On top of the paper towel dispenser, was a light peach colored toothbrush, dirty with hairs, without a name label on it.

Room # 728 – On an inner washroom door hook, there was a cloth storage bag with a bed pan in it. The cloth bag was dirty with dried matter of various colours and stained yellow in areas. The bed pan within was dirty with heavy accumulation of dust.

Room # 730 – On the washroom sink counter, there was a pink basin with heavily used razors, and some nail clippers, none of which were labelled with a resident's name.

Room # 729 – On the floor, under the washroom sink, there was a pink washbasin with a bed pan in it. The bed pan was dirty with dried yellowish residue, and was cracked at the narrow end.

Room #727 – On a hook within the washroom, there was a cloth storage bag that contained 2 UCH's and a bed pan. One of the UHC's was dirty with dried yellow spots. When the inspector lifted the bed pan out of the bag, it was noted that a single dusty glove was stuck to it. The cloth storage bag was stained and dirty with dried matter.

Room #832 – On a hook within the washroom, there was a cloth storage bag that was dirty with dried matter and stained. The bag contained empty bottles of mouthwash and perineum cleaner.

Room # 328 – On the floor, under the washroom sink, there was a green resident washbasin and a pink resident washbasin.

With regards to resident's personal care items, such as razors and toothbrushes, the Clinical Coordinator confirmed, on March 6th, 2014, that all such items should be labelled with the resident's name. The Clinical Coordinator explained that there is a formal process in place to ensure this occurs for residents upon admission, as required by O. Reg. 79/10, s. 89 (1) a. ii., and that unit nursing staff are expected to ensure that this continues throughout the resident's stay at the home.

With regards to the cloth storage bags, on March 6th, 2014, the Clinical Coordinator explained that the home has formally discontinued use of the cloth storage bags because they cannot be kept clean and sanitary, and there should not be any in use on the care units.

With regards to items such as UHC's and washbasins, on March 6th, 2014, the Clinical Coordinator clarified that the UHC's are for one time use only, and that nursing staff should discard them after use. Similarly, it is expected that unit nursing staff ensure that resident's washbasins are clean and stored in an appropriate manner that avoids contamination, such as within a dresser drawer. [s. 229. (4)]

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 with the requirement that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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. (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 S.O.2007, c.8, s.6 (7) in that the licensee specifically failed to ensure that the care set out in the plan of care of Resident #1 was provided to the resident as specified in the plan.

Resident #1 was admitted to the home on a day in December, 2013. Resident #1 no longer resided at the home at the time of the inspection. On March 4th, 2014, the inspector reviewed the initial physiotherapy assessment that was completed for resident #1, 8 days following their admission. The assessment identified that the resident needed two person physical assistance for transfers. Resident #1's plan of care, initiated 12 days following their admission, was also reviewed and it stated that Resident #1 " Requires support for transfers as evidenced by inability to complete task on own, Requires weight bearing assistance (extensive)(side by side) transfer and two staff".

On March 5th, 2014, the inspector interviewed nursing Staff member #101 about Resident #1, in relation to lifts and transfers. Staff #101 indicated to the inspector that resident #1 required a two person transfer upon admission, as their status was not known, but that later, the resident only required a one person transfer for all transfers.

The " Activities of Daily Living – Transferring" report, from the Point of Care program, for the period of an identified day in December 2013, to an identified day in January 2014, for Resident #1, was reviewed by the inspector. It was recorded by 8 different nursing staff members, including staff #101, on 18 different occasions, during the 29 day time frame, that resident #1 was transferred by one person physical assistance.

On March 6th, 2014, the Clinical Coordinator confirmed to the inspector their understanding of the need for resident #1 to be transferred by two staff members, given the resident's physical condition.

Resident #1's care set out in the plan of care, to have two staff members perform all transfers, was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were

involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s.107 (1) 5. in that the licensee failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease.

On March 4, 2014, Inspector #133 and Inspector #573 arrived at the home to begin a Complaint Inspection. Upon entry to the home, the inspectors were informed that the home was experiencing an outbreak of enteric illness. The home's Director of Care and Clinical Coordinator indicated they had not informed the Director of the Ministry of Health and Long Term Care (MOHLTC), and no evidence was provided to the inspectors that anyone else within the home had informed the Director of MOHLTC. The Clinical Coordinator explained that the outbreak had been officially declared on February 22, 2014, by a representative from Ottawa Public Health. [s. 107. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s.107 (4) in that the licensee failed to make a written report to the Director, within 10 days of becoming aware of an outbreak of enteric illness.

On March 4, 2014, Inspector #133 and Inspector #573 arrived at the home to begin a Complaint Inspection. Upon entry to the home, the inspectors were informed that the home was experiencing an outbreak of enteric illness. The outbreak was not reported immediately to the Director as was required. A written report was not submitted to the Director, within 10 days, as was required. Following discussion with the inspector, on March 6th, 2014, the home submitted a written report to the Director, with all of the required information, as per O. Reg. 79/10, s.107 (4) 1-5. It is noted, however, that the Critical Incident Report erroneously indicated that the enteric outbreak was declared by Ottawa Public Health on February 23, 2014. Inspector #133 spoke with a representative from Ottawa Public Health on March 14, 2014, who confirmed that the home's enteric outbreak was declared on February 22, 2014. [s. 107. (4)]

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Issued on this 27th day of March, 2014

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

Jessica Lapensée, #133 & on behalf of inspector #573, Arandraj Natarajan