Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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

☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
February 1, 2011	2011_117_2420_01Feb115353	Critical Incident Log # O-000231

Licensee/Titulaire

Revera Long Term Care Inc.
55 Standish Court, 8th floor
Mississauga ON
L5R 4B2
Fax: (289).360.1201

Long-Term Care Home/Foyer de soins de longue durée

Carlingview Manor
2330 Carling Avenue
Ottawa, ON
K2B 7H1
Fax: (613) 820-9774

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to the abuse of a resident.

During the course of the inspection, the inspector spoke with the home's Executive Officer, to the home's Director of Care, to a Registered Nurse, to a Personal Support Worker and to the identified resident.

During the course of the inspection, the inspector reviewed the identified resident's health care record and observed a resident room.

The following Inspection Protocol was used during this inspection:

- Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

2 WN
1 VPC
1 CO: #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. On January 28 2011, at approximately 11 am, a Personal Support Worker was seen by a Personal Support Worker student to be "beating" and pulling off the shirt of a resident, in the resident's room. This fact was reported in person to the Personal Support Worker student's school supervisor at approximately 12:00 on January 28, 2011 and to the home's Administrator in writing at approximately 14:45 on January 28, 2011.

2. The Personal Support Worker student reported that when she told the Personal Support Worker that this was wrong, the Personal Support Worker responded by saying that the resident had bit her and that was why she hit the resident.

3. The resident's plan of care indicates that if the resident is aggressive or resistive to care, staff are to leave the resident and return within 5-10 minutes. Staff are also directed to distract the resident through conversation in attempt to get the resident to accept care.

4. The home's Administrator and Director of Care interviewed the Personal Support Worker who was seen to be "beating" the resident on January 29, 2011. They state that the Personal Support Worker told them that she did not stop, leave the resident and return within 5-10 minutes, as indicated in the resident's plan of care, when the resident was physically aggressive and resistive to care on January 28, 2011.

5. The home's Documentation Registered Practical Nurse assessed the resident at approximately 15:30 on January 28, 2011. It was noted that the resident had new and old bruises to right hand and forearm. The causes of the bruises are unknown.

Compliance Order #001 was faxed to the licensee- See Order Report

Inspector ID #:	# 117

WN #2: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. The resident's plan of care indicates that if the resident is aggressive or resistive to care, staff are to leave the resident and return within 5-10 minutes. Staff are also directed to distract the resident through conversation in attempt to get the resident to accept care.

2. The home's Administrator and Director of Care interviewed the Personal Support Worker who was seen to be "beating" the resident on January 29, 2011. They state that the Personal Support Worker told them that she did not stop, leave the resident and return within 5-10 minutes, as indicated in the resident's plan of care, when the resident was physically aggressive and resistive to care on January 28, 2011

Inspector ID #:	# 117

Additional Required Actions:

VPC #1 - 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 regarding the need to ensure that the care set out in the resident Dorothy Stanton's plan of care is provided to the resident Dorothy Stanton as specified in her plan, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Lynn Duchesne
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). February 9, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	X Public Copy/Copie Public	
Name of Inspector:	Lyne Duchesne	**Inspector ID #**	117
Log #:	O-000231		
Inspection Report #:	2011_117_2420_01Feb115353		
Type of Inspection:	Critical Incident		
Date of Inspection:	February 1, 2011		
Licensee:	Revera Long Term Care Inc. 55 Standish Court, 8th floor Mississauga ON L5R 4B2 Fax: (289).360.1201		
LTC Home:	Carlingview Manor 2330 Carling Avenue Ottawa, ON K2B 7H1 Fax: (613) 820-9774		
Name of Administrator:	Cathy Drouin		

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s.3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that every resident be protected from abuse and that every resident be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by February 11, 2011 via fax # (613) 569-9670

Grounds:

1. On January 28 2011, at approximately 11 am, a Personal Support Worker was seen by a Personal Support Worker student to be "beating" and pulling off the shirt of the resident, in the resident's room # 501. This fact was reported in person to the Personal Support Worker student's school supervisor at approximately 12:00 on January 28, 2011 and to the home's Administrator in writing at approximately 14:45 on January 28, 2011.

2. The Personal Support Worker student reported that when she told the Personal Support Worker that this was wrong, the Personal Support Worker responded by saying that the resident had bit her and that was why she hit the resident.

3. The resident's plan of care indicates that if the resident is aggressive or resistive to care, staff are to leave the resident and return within 5-10 minutes. Staff are also directed to distract the resident through conversation in attempt to get the resident to accept care.

4. The home's Administrator and Director of Care interviewed the Personal Support Worker who was seen to be "beating" the resident on January 29, 2011. They state that the Personal Support Worker told them that she did not stop, leave the resident and return within 5-10 minutes, as indicated in the resident's plan of care, when the resident was physically aggressive and resistive to care on January 28, 2011.

5. The home's Documentation Registered Practical Nurse assessed the resident at approximately 15:30 on January 28, 2011. It was noted that the resident had new and old bruises to right hand and forearm. The causes of the bruises are unknown.

This order must be complied with by:	February 18, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007*.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;

(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 9th day of February, 2011.	
Signature of Inspector:	Lyne Duchesne
Name of Inspector:	Lyne Duchesne
Service Area Office:	Ottawa