



**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
prévus le Loi de 2007 les
foyers de soins de longue**

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
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 22, 23, 24, 26, 29, 30, 31, Nov 1, 2012	2012_193150_0006	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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Manager, Registered Staff.

During the course of the inspection, the inspector(s) reviewed the resident's health records, the home's investigation report, the home's correspondence with family member and policy #LTC-A-120 Admission, transfers, discharges and Death, Palliative Care Services #LTC-C-170 dated September 2001.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, 107 (5), in that the resident's substitute decision-maker was not promptly notified of the resident's death.

In July 2012, the POA left written directives on the unit indicating that "should there be a change in her health for the worse by then, please reach me at the identified phone number or my secure email".

In July 2012, the resident passed away.

The home's investigation report indicates that a staff member called two of the given numbers indicated on the POA written directives. The phone rang many times without any answer and the staff did not leave any message indicating to call the nursing home.

The administrator confirmed that the following shift did not follow-up on informing the POA.

The POA was informed 12 hours after the resident passed away.

Issued on this 1st day of November, 2012



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

A handwritten signature in cursive script, appearing to read "Emily Baul", is written within the signature box.