Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 5, 2015	2015_330573_0018	O-000929-14	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

ANANDRAJ NATARAJAN (573)

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, 2015, July 2, and 3, 2015 (3 days)

For the following logs:
O-000929-14
O-001460-14
O-001686-15
O-002173-15
O-002324-15

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager for Resident Care (PMRC), the RAI-MDS Coordinator, three Registered nurses (RN), two registered practical nurses (RPN), one Physiotherapy Assistant and several personal supports workers (PSW).

In addition, the inspector reviewed five Critical Incident (CI) reports, reviewed identified residents' health records (including care plans, progress notes, medication administration records, flow sheets, hospital discharge summaries), and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the Resident #04's plan of care is documented [O-002173-15] .

The Critical Incident Report #M508-000009-15 for Resident #04 indicated that on a specific day and time resident was found lying on the floor in a puddle of urine. The Critical Incident Report also indicated that Resident was taken to hospital and had a diagnosis of multiple fractures.

Inspector #573 reviewed Resident #04's plan of care in effect at the time of the incident which indicates that resident has bladder incontinence and also identifies that resident is at high risk for falls. Upon further review of plan of care the interventions in place for Continence Care Assistance /Urinary Incontinence and for Fall prevention which includes a scheduled toileting routine for Resident #04, which is toileting resident before and after every meals (i:e Breakfast / Lunch/ Supper) and before Resident #04's bed time at night.

During the review of the Toileting Program documentation sheet for Resident #04, Inspector #573 found no documentation on 5 specific days prior to the fall indicating that Resident #04 was toileted before, after supper and also before bed time as per the scheduled toileting program as specified in the plan of care.

On July 3, 2015 Inspector #573 interviewed In-charge RN Staff #101 about Resident #04, in relation to scheduled toileting routine documentation sheet, who indicated that the Resident #04 was provided with a scheduled toileting routine by PSW staffs but it was not documented in the toileting routine documentation sheet.

On July 3, 2015 Inspector #573 and Program Manager for Resident Care(PMRC) both reviewed Resident #04's Toileting routine documentation and the PMRC concurred with the inspector that there is no documentation that Resident #04 was toileted on 5 specific days prior to the fall by the PSW staffs before and after supper and also at the bed time as per the plan. Further the Program Manager for Resident Care indicated to Inspector #573 that the expectation of the PSW staffs is to document when a resident is toileted or any care is provided to the residents. [s. 6. (9) 1.]

WN #2: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital [O-002324-15].

On a specific day and time Resident #05 had an unwitnessed fall. Resident was transferred to the hospital immediately and diagnosed with a Hip fracture. Resident #05's Progress note documentation on a specific day indicates Resident #05 remains at the hospital and will be having surgery for Hip fracture.

During an interview the Program Manager for Resident Care indicated to Inspector #573 that Resident #05's fall resulted in significant change in the Resident's health status.

On a specific day the Director was informed of the significant change in the Resident 05's health status due to the fall, which is four (4) business days after the occurrence of the incident. [s. 107. (3) 4.]

Issued on this 5th day of August, 2015

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

Original report signed by the inspector.