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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 5, 2017	2017_617148_0018	029145-16, 031567-16, 033529-16, 003238-17, 003945-17, 005051-17, 008333-17, 008419-17, 009711-17	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

AMANDA NIXON (148)

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 13, 14, 15, 19, 22 and 23, 2017

This inspection included nine critical incident reports, four related to alleged resident abuse and five related to an injury that resulted in hospital transfer and change in health condition.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Program Manager of Resident Care, Program Manager of Personal Care, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector also reviewed resident health care records and related documents and the licensee's investigations into alleged abuse, as applicable. Observations were also made of resident care and services, the resident's environment and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #001 and resident #005, sets out clear directions to staff who provide direct care to the resident.

A critical incident report was submitted to the Director on a specified date, describing that during the night shift of the same date, resident #001 was discovered to have bruising of an unknown cause. The home conducted an investigation into the bruising and found that the resident had been provided a two person side by side transfer during the evening shift. It was not clear if the bruising was caused by the transfer technique utilized.

Inspector #148 reviewed the plan of care for resident #001 that was in place at the time the bruising was discovered. The plan of care indicated that due to increased fatigue on evenings, the resident required transfer by use of a Sara lift. The plan of care did not specify the required transfer technique on the day shift. In speaking with the Program Manager of Resident Care, it was described to the Inspector that staff were expected to use the Sara lift with resident #001 after 1500 hours (the start of the evening shift).

In review of the investigation conducted by the Program Manager of Resident Care, it was noted that at the time of the discovery of the bruising, the resident had three transfer logos (picture diagrams) at the head of bed to direct staff in the provision of transfers for resident #001. The three logos included: 1 person transfer, 2 person side by side transfer, 2 person Sara lift (with "Evenings" noted in the top corner).

The Inspector spoke with two regular day shift PSWs, who regularly provide care to resident #001. In discussion of the resident's transfer needs prior to the discovery of the bruising, it was reported that the transfer technique used would depended on the needs of the resident at the time the transfer was required. PSW #105 noted that if the resident was fatigued, for example could not follow directions, then the staff would use the two person side by side transfer; if the resident was alert the staff would use the one person transfer.

The Inspector spoke with the two PSW staff persons who provided care to resident #001 on the evening shift prior to the discovery of the bruising. PSW #107 described that there were three logos at the head of bed that directed staff in the transfers of resident #001. PSW #107 noted that if the resident was able to weight bear and able to follow directions then the staff would use a two person transfer. When asked about the use of a one person transfer or use of Sara lift, PSW #107 indicated that the resident was always

transferred by two people side by side. PSW #107 noted that if the resident was not following directions then a mechanical lift would be used, not the Sara lift. PSW #107 could not recall a time when the Sara lift was used for this resident. PSW #106, described that resident #001 had transfer needs posted at the head of bed but that she only ever used the two person side by side transfer for this resident. When asked when a one person transfer or Sara lift would be used for this resident, PSW #106 reported that she did not know of a circumstance when a one person transfer would be appropriate for resident #001 and that if the resident was tired or not following instructions that the full mechanical lift would be used, not the Sara lift. PSW #106 and PSW #107 both indicated that a two person side by side transfer was used on the evening prior to the discovery of the bruising; neither staff noted any incident or unusual occurrence in the provision of the resident's transfer.

Further to the above, the plan of care was updated after the resident's return from hospital soon after the discovery of the bruising, to indicate that on evening shift, the resident would be a two person transfer but if fatigued would be transferred by use of mechanical lift. No further instruction was provided for transfers on the day shift. Days after this update, the plan of care was subsequently updated to indicate that all transfers would be completed by use of the mechanical lift.

The plan of care did not set out clear directions to staff who provided direct care to resident #001, as it relates to the transfer needs of the resident. [s. 6. (1) (c)]

2. A critical incident report was submitted to the Director on a specified date, describing that resident #005 fell from a wheelchair while trying to stand up and self-transfer out of the wheelchair. The resident was sent to hospital and diagnosed with an injury.

In review of the resident's health care record, the progress notes of February and March 2017 indicate that the resident used the wheelchair and intermittently had a table top applied to the wheelchair. The plan of care in place at the time of the fall, indicated that the resident uses a walker and uses a wheelchair when unable to ambulate. The use of a table top was not captured in the plan of care. The current plan of care indicates that the resident uses a wheelchair but will remove the table top. The application and use of the table top are not set out in the plan of care. Inspector #148 observed the resident over the course of the inspection and it was noted that the table top was applied when the resident was seated in the wheelchair.

Inspector #148 spoke with the RN present at the time of the described fall. RN #108

stated that the resident was seated in the wheelchair, facing the communication station. To the recollection of RN #108, the resident did not have the table top applied at the time. When asked, RN #108 reported that the table top was used when the resident was trying to stand up out of the chair. Items of interest would be placed on the table top to provide the resident with a distraction.

Inspector #148 spoke with three PSW staff persons who provide direct care to resident #005, PSW staff indicated that that table top was used occasionally to place items of interest or provide the resident with a place to rest his/her arms; the resident was known to push the table top off.

The plan of care for resident #005 did not set out clear directions as it relates to the application and use of a table top. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, the Program Manager for Personal Care submitted a critical incident report to the Director, describing that on the day prior, resident #008 reported that PSW #107 had been rude and arrogant towards him/her at the meal service making the resident feel humiliated. The Program Manager for Personal Care spoke with the resident, on the same day that the report was made. The resident further described that the staff person was authoritative, using a rough and rude tone during the supper meal service and that he/she was greatly upset by how he/she was treated. The Manager placed PSW #107 on leave that same day, pending an investigation into the resident's report.

The Manager had reasonable grounds to suspect abuse, however, did not report the matter to the Director until one day after the information was obtained. [s. 24. (1)]

Issued on this 5th day of July, 2017

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

Original report signed by the inspector.