Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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 rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 7, 2021 | 2021_548756_0006 | 003229-20, 004795-20, 007968-20, 013552-20, 015128-20, 015771-20, 019461-20, 024714-20, 025030-20, 025768-20, 004268-21 | 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

LISA CUMMINGS (756), LINDA HARKINS (126)

## 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): March 3-5, 8-11, 16-18, 2021.**

**The following intakes were completed in the Critical Incident System Inspection:**
**- Log #025030-20, CIS #M508-000041-20; Log #024714-20, CIS #M508-000040-20; Log #013552-20, CIS #M508-000020-20; Log # 019461-20, CIS #M508-000032-20; and Log #015128-20, CIS #M508-000021-20 were related to falls**
**- Log #007968-20, CIS #M508-000014-20; Log #003229-20, CIS #M508-000008-20; Log #004795-20, CIS #M508-000012-20; and Log #025768-20, CIS #M508-000044-20 were related to allegations of abuse**
**- Log #015771-20, CIS #M508-000025-20 was related to an allegation of improper care**
**- Log #004268-21, CIS #M508-000006-21 was related to an unexpected death**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Managers of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Housekeeper and residents.**

**During the course of the inspection, the inspectors observed the provision of resident care and services including meal delivery, observed residents rooms and resident home areas, observed the entrance of the home, and observed the interaction between residents. A review of relevant records was also completed including several resident health care records, licensee internal investigation documents, and licensee policy 'Falls Prevention Program', revised October 2020.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 30. Protection from certain restraining**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:**
**1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).**
**2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).**
**3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was not restrained by the use of physical barriers from leaving their room.

The resident's room was observed to have a barrier blocking the doorway, which would have prevented entry or exit. The resident was observed inside their room, laying in bed.

The PSW explained that the resident was on isolation precautions and that staff had placed the barrier in the doorway to prevent the resident from leaving their room.

Sources: observations of the resident's room, interviews with a PSW and others. [s. 30. (1) 1.]

**Issued on this 8th day of April, 2021**

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

**Original report signed by the inspector.**