Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 8, 2022
Inspection Number 2022_1534_0003
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
City of Ottawa

Long-Term Care Home and City
Carleton Lodge, Nepean

Lead Inspector
Cheryl Leach (719340)

Additional Inspector(s)
Andy Natarajan (573)
Erica McFadyen (740804)

Inspector Digital Signature
Cheryl Leach
Digitally signed by Cheryl Leach
Date: 2022.09.11 20:35:44 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15, 17, 18, 22, 23, 24, 25, 26, 29, 30, 31, September 1 and 2, 2022.

The following intake(s) were inspected:

-Log #010952-22 (CIS #M508-000021-22) related to concern regarding short staffing, neglect, continence care, bathing, dining and snack service.
-Log #012362-22 (CIS #M508-000023-22) related to a fall resulting in transfer to hospital and a significant change in condition.
-Log #012324-22 (CIS #M508-000022-22) related to a fall resulting in transfer to hospital and a significant change in condition.
-Log #010544-22 (CIS #M508-000017-22) related to choking incident resulting in transfer to hospital.
-Log #010399-22 (CIS #M508-000016-22) related to staff to resident abuse.
-Log #009181-22 (CIS #M508-000011-22) related to a fall resulting in transfer to hospital and a significant change in condition.
-Log #008853-22 (CIS #M508-000009-22) related to resident to resident altercation resulting in transfer to hospital.
-Log #014969-22 (CIS #M508-000033-22) related to a fall resulting in transfer to hospital and a significant change in condition.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [DUTY OF LICENSEE TO COMPLY WITH PLAN]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary:
A Critical Incident Report submitted by the licensee to the Ministry of Long-Term Care (MLTC), indicated that on a specified day a resident was provided with the wrong texture diet that resulted in a choking incident.

The inspector reviewed the resident's plan of care for nutrition which indicated the resident's required diet texture.

In an interview, the Manager of Resident Care indicated that the resident was given an incorrect meal texture. Staff failed to provide the correct texture diet as specified in the resident's plan of care that resulted in actual harm to the resident.

Sources: resident's plan of care, interview with the Manager of Resident Care and other staff.

[573]

WRITTEN NOTIFICATION [INTEGRATION OF ASSESSMENTS, CARE]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (4) (a)
The licensee has failed to ensure that staff and others involved in the different aspects of resident's care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Rationale and Summary:
A Critical Incident Report was submitted to the MLTC. The report indicated that on a specified day a resident sustained a fall and declined in their mobility. An X- ray was completed and revealed evidence of an injury and the resident was transferred to the hospital for further treatment.

A review of the resident's health care record indicated that the physician requested a physiotherapy assessment related to decline in the resident's mobility post fall. An interview with the home's physiotherapist verified that they received the resident's physiotherapy referral and a follow up assessment for the referral was not completed. When staff involved in the resident's care failed to collaborate with each other in the assessment of the resident, there was a potential risk of delayed treatment and negative health outcomes.

Sources: Resident's health care records, interview with the physiotherapist and other staff members.

[573]

WRITTEN NOTIFICATION [AIR TEMPERATURE]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 r. 24 (3)

The licensee has failed to ensure that the air temperature of one resident common area on every floor, and every designated cooling area, was measured and documented at least once every afternoon between 12pm and 5pm.

Rationale and Summary:
Inspector reviewed the record of the licensee's air temperature measurement documentation from August 01 to August 17, 2022. Upon review, for 12 days the air temperature of one resident common area on every floor, and the designated cooling area, was not measured and documented in the afternoon hours between 12pm and 5pm.

The inspector spoke with the Maintenance Supervisor and they confirmed that on the weekdays their staff failed to measure and document the air temperature of one resident common area on every floor, and the designated cooling area, in the afternoon hours. There was a potential risk to the residents' comfort and safety as air temperatures in the specified areas of the home were not measured and documented in the afternoon hours.

Sources: LTCH's Air temperature documentation records and interview with the Maintenance Supervisor.

[573]

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca