

Inspection Report Under the Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 420 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 19, 2023
Inspection Number: 2023-1534-0005
Inspection Type:
Complaint
Critical Incident System
Licensee: City of Ottawa
Long Term Care Home and City: Carleton Lodge, Nepean

Lead Inspector

Karen Buness (720483)

Inspector Digital Signature

Additional Inspector(s)

Ashley Martin was present throughout the inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 30, 2023 and April 3, 4, 6, 12, 2023

The following intake(s) were inspected:

- Intake: #00008046 Fall of resident resulting in a significant change in health status
- Intake: #00013285 Complaint related to resident care and services.
- Intake: #00014663 Fall of resident resulting in a significant change in health status.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services Infection Prevention and Control Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 6 (7)

Rationale and Summary:

A resident had an unwitnessed fall. Documentation in the resident's health record revealed the bed alarm was in place but not functioning at the time of the fall.

During an interview with a RPN, the RPN reported after the resident had fallen it was discovered that that the bed alarm was in place but not functioning. A RN also confirmed the bed alarm was not functioning at the time of the fall.

The resident's Care Plan indicates the resident is at a risk for falls and includes individualized prevention strategies towards preventing falls. The resident's Kardex provides clear direction to the staff which includes the use a bed alarm when resident is in bed as a falls prevention strategy.

Impact/Risk Failure to ensure all prevention strategies were in place put the resident at a higher risks for falls.

Source: Resident's electronic health record and interviews with registered staff.

[720483]