Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 29, 2023	
Inspection Number: 2023-1534-0007	
Inspection Type: Complaint Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Carleton Lodge, Nepean	
Lead Inspector Martin Orr (000747)	**Inspector Digital Signature**
Additional Inspector(s) Dee Colborne (000721) Lisa Cummings (756)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, 16, 17, 18, 21, 2023.

The following intakes were inspected:
Intake: #00091787-CI: M508-000018-23- related to an allegation of staff to resident abuse.
Intake: #00091794-CI: M508-000021-23- related to an allegation of staff to resident abuse.
Intake: #00090521-CI: M508-000014-23- related to an allegation of staff to resident abuse.
Intake: #00091792-CI: M508-000020-23- related to an allegation of staff to resident abuse.
Intake: #00091788-CI: M508-000019-23- related to an allegation of staff to resident abuse.
Intake: #00092093-CI: M508-000022-23- related to an allegation of resident-to-resident abuse.
Intake: #00093796 complaint regarding personal care and services.
Intake: #00092766 complaint regarding personal care and services.

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

Resident Care and Support Services

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care-when reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the plan of care was reviewed and revised when the care set out in the plan is no longer necessary.

Rationale and Summary
The resident's plan of care indicated that they were not to be left in their room unattended as they were at risk of self-transferring to the bathroom.

The resident was observed in their room on four dates, the resident was observed to be asleep, seated in their wheelchair, and alone in the room.

A Registered Nurse and a Personal Support Worker identified that the resident was now able to stay in their room unattended as they have a chair and a bed alarm in place that will notify staff if the resident attempts to self-transfer.

Failing to revise the plan of care when the resident was able to remain in their room unattended could have create inconsistent practice and may not have met the preferences of the resident.

Sources: Observations; Careplan; Interviews with a PSW and a RN.

[756]

WRITTEN NOTIFICATION: Duty of Licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
The resident's plan of care indicated that staff were to assist the resident with dental care.

Three Personal Support Workers identified that the resident was assisted to stand at the sink and with set-up for dental care in the morning and in the evening, not after each meal as specified in the plan. This was supported in the daily flowsheets which identified the resident received the assistance for dental care twice a day. The three PSWs explained that the resident independently completes dental care once set-up and preferred to use a manual toothbrush. However, there was no documentation that identified that the resident refused to use other dental equipment.

The resident confirmed they performed dental care standing at the sink twice a day after staff assisted them with the transfer to the bathroom and with set-up of the toothbrush. Further, the resident stated they preferred to use a manual toothbrush and not other dental equipment as specified in the plan of care.

Failing to provide care as specified in the plan could create a risk to the resident’s oral tissues.

Sources: Careplan; Flowsheets; Interviews with three PSW's and the resident.

[756]

ii. The licensee has failed to ensure that the care set out in the plan of care regarding assistance with transfers, dressing, and ambulation, was provided as specified in the plan.

Rationale and Summary
The resident's plan of care indicated that the resident required one staff assistance with transfers, dressing and when walking. A PSW and a Registered Nurse further explained that the resident required staff to stand beside them when they were ambulating.

Video footage was provided by the resident's Substitute Decision Maker (SDM) which was identified as footage from a specific shift. The footage showed a staff member come into resident room, turned off the bed alarm, and then remained at the bedroom door. The resident had self-transferred to the toilet prior to the staff member entering the room. However, after the staff member was in the room, the resident independently transferred from seated on the toilet to standing, independently raised their pants, and then independently began to ambulate towards their bed. Once the resident exited the bathroom, the staff member walked further into the resident's room but remained on the opposite side of the bed from the resident.

The video footage was shown to the Program Manager who confirmed the resident required the assistance of one staff member for transfers, dressing, and ambulation.

Failing to follow the plan of care in regard to transfers, dressing and ambulation could have placed the resident at increased risk of falls.

Sources: Careplan; Video footage; Interviews with a PSW, an RN, and the Program Manager.

[756]

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

Rationale and Summary
The resident's plan of care indicated that the resident required a device when seated in their wheelchair and that the device was to be attached to the resident's clothing.

The resident was observed in their room, asleep in their wheelchair. The device was not attached to the resident's clothing and was found hanging to the right side of the wheelchair. A PSW identified they were caring for the resident on this day and that they did apply the device to the resident's clothing earlier in the day. The PSW stated the resident likely removed the device themselves.

Failing to ensure the device was in place may have increased the risk of falls due to a self-transfer.

Sources: Careplan; Observation; Interview with a PSW .

[756]