Ontario

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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 08, 2024	
Inspection Number: 2024-1534-0001	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Carleton Lodge, Nepean	
Lead Inspector Saba Wardak (000732)	**Inspector Digital Signature** Saba Wardak Digitally signed by Saba Wardak Date: 2024.02.21 10:52:46 -05'00'
Additional Inspector(s) Mark McGill (733)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 4-5, 8-12, 15-16, 2024.
The following intake(s) were inspected:

- Intake: #00097750 [CI #M508-000025-23] , Intake: #00102074 [CI #M508-000032-23]-related to written complaints about medication management
- Intake: #00100930 [CI #M508-000030-23]- related to an unwitnessed fall resulting in a significant change in condition
- Intake: #00102572 [CI #M508-000033-23]- related to alleged staff to resident emotional abuse
- Intake: #00102876 [CI #M508-000037-23]- related to alleged resident to resident sexual abuse

- Intake: #00099421 [CI #M508-000028-23], Intake: #00096567 [CI #M508-000024-23], Intake: #00100326 [CI #M508-000029-23]- related to falls prevention and management

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A resident was prescribed a medication with instructions to reassess the medication in a specific span of time. Registered staff did not transcribe this order correctly by failing to note the re-assessment instructions. Subsequently, once the specific time had lapsed, the medication was discontinued by the pharmacy as per their policy and the medication was not re-assessed. As a result, the resident did not receive the medication for a period of twenty (20) days.

On a separate occasion, the dose of a medication was increased for the same resident, however, registered staff failed to follow-up with the order and therefore, the pharmacy was not made aware of the increase in dosage. As a result, the resident did not receive the increased dose of medication for a period of two days.

Failing to follow-up with both medication orders, posed a risk to the resident as the errors had the potential to delay or not achieve a therapeutic drug level.

Sources: Interview with Program Manager – Nursing, Medication Incident Reports, chart review including resident's progress notes and medication orders.
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