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
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Original Public Report

Report Issue Date: March 26, 2024
Inspection Number: 2024-1534-0002
Inspection Type: Complaint Critical Incident
Licensee: City of Ottawa
Long Term Care Home and City: Carleton Lodge, Nepean

Lead Inspector Erica McFadyen (740804)	Inspector Digital Signature Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2024.04.08 15:02:11 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27 and 29, 2024 and March 1, 4-8, and 12-15, 2024

The following intake(s) were inspected:

- Intake: #00102840 / CIS M508-000036-23 and Intake: #00105801/ CIS M508-000001-24 related to care services
- Intake: #00105857/ CIS M508-000002-24 - Fall of a resident resulting in injury
- Intake: #00106452/ Complaint about care of a resident in the long-term care home and confidentiality
- Intake: #00107091/ Intake: #00110135- complaint about the care of a resident in the long-term care home
- Intake: #00107122 - CIS M508-000008-24- related to building services

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 3 (1) 17.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
17. Every resident has the right to be told both who is responsible for and who is

providing the resident's direct care.

The licensee has failed to ensure that the resident right to be told who is providing their care was upheld.

Rationale and Summary
On a specified date on a specified unit three Personal Support Workers (PSWs) were observed to not be wearing name tags while engaged in the provision of resident care. In an interview with the Program Manager of Resident Care (PMRC) it was stated that when the staff were not wearing name tags residents may not have known who was providing their care.

Sources
Observations on a specified unit, interview with the PMRC

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Date Remedy Implemented: March 14, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for resident #001 sets out clear direction to staff and others who provide care to the resident.

Rationale and Summary
Review of the clinical documentation for a resident on a specified date by a registered nurse (RN) and registered practical nurse (RPN) stated that taking narcotics on leave of absence (LOA) was not permitted per Carleton Lodge policy.

Documentation on a different specified date by an RPN stated that medications and narcotics were provided for the resident's LOA.

Documentation on a specified date by an RPN stated that narcotics were not dispensed to the to the resident while on LOA.

For documentation on two different dates in the same month it was charted that the narcotics were provided for the resident's LOA.

In an interview with the PMRC it was stated that there were no special considerations related to sending narcotics on LOA with the resident and that narcotics should be sent on LOA if required. In an interview with the Program Manager of Personal Care (PMPC) it was stated they were unaware of any special considerations related to the dispensing of narcotics for the resident while on LOA.

In an interview with the Acting Administrator it was stated that the medication plan of care related to narcotics for the resident was not clear.

The impact of the unclear medication plan of care is that the resident did not consistently receive their narcotic while on LOA.

Sources
Review of the clinical record for the resident, interviews with the PMRC, PMPC, and Acting Administrator

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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

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

Rationale and Summary
A review of the care plan for a resident stated that their oral plan of care was for staff to assist with the brushing of the tongue, gums, and all other areas of the resident's mouth in the morning and before bedtime. In an interview with PSW #101 it was stated that they provide oral care to the resident by wiping the gums and tongue with a soft cloth. In an interview with PSW #102 it was stated that they provide oral care to the resident by cleaning the mouth with mouthwash. In an interview with PSW #102 it was stated that they did not follow the resident's oral plan of care. In an interview with the PMRC it was confirmed that the oral plan of care for the resident was to brush the tongue, gums and mouth and that the plan of care was not followed by PSW #101 and #102.

The risk of not providing dental care as per the plan of care for the resident is that

they may not have received oral care that met their needs.

Sources
Interviews with PSW #101 and #102, interview with the PMRC, record review for the resident

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WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary
On a specified date a resident underwent a specified surgery.

A review of the resident's electronic record found that there were no assessments of the surgical sites using a clinically appropriate tool, and no assessment included within the progress notes on eight of the nine days following the specified surgery.

In an interview with the PMRC it was stated that the surgical sites were not assessed using a clinically appropriate tool on any date.

The risk of not documenting assessments of the surgical sites following surgery is that potential complications arising from that surgery may not be adequately assessed.

Sources
Review of the clinical record for the resident, interview with the PMRC
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WRITTEN NOTIFICATION: Dealing with complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to ensure that every written complaint made to the licensee receives a response which includes: the contact information for the patient ombudsman, the Ministry's toll-free telephone number for making complaints, a description of the actions taken to resolve the complaint, and confirmation that the complaint has been submitted to the Director.

Rationale and Summary
CIS Report #M508-000036-23 indicated that a complaint was made to the long-term care home regarding the care of a resident on a specified date. During a review of the written correspondence between the complainant and the Acting Administrator no information could be located regarding the Ministry's toll-free telephone number for making complaints, contact information for the patient ombudsman, an explanation of what the licensee had done to resolve the complaint, or confirmation that the information was forwarded to the Director.

During an interview with the Acting Administrator it was stated that the above information was not provided in the long-term care home's response to the complainant.

The risk of not including the required information in the complaint response is that the complainant may not be made aware of resources to assist them or the steps that the long-term care home has taken to address their complaint.

Sources
Review of CIS Report #M508-000036-23, review of correspondence between the complainant and the Acting Administrator, interview with the Acting Administrator.

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