Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 13, 2014 | 2014_230134_0008 | O-000025-14 , O-000183-14 | Critical Incident System |

**Licensee/Titulaire de permis**

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

**Long-Term Care Home/Foyer de soins de longue durée**

CARLETON LODGE
55 LODGE ROAD, R. R. #2, NEPEAN, ON, K2C-3H1

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

COLETTE ASSELIN (134), ANANDRAJ NATARAJAN (573)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): March 6, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, two Program Managers, one Registered Nurse, the RAI Coordinator, one Personal Support Worker and Resident #01**

**During the course of the inspection, the inspector(s) toured the home, reviewed Resident #01's health records and reviewed three critical incident reports.**

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

**Falls Prevention**
**Reporting and Complaints**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg. 79/10 section 107 (1) 5, whereby the Director was not informed immediately of two outbreaks of communicable disease as defined by the Health Protection and Promotion Act.

The Program Manager was interviewed by Inspector #134 and Inspector #573, who indicated the home had been declared in Respiratory and Enteric Outbreak by the Public Health Unit on January 22, 2014.

The Director was informed of the two outbreaks via the Critical Incident System March 3, 2014. [s. 107. (1)]

2. The licensee failed to comply with the O. Reg 79/10 section 107.(3.1)(b), whereby the Director was not informed within three business days after the occurrence of an incident that caused an injury for which the resident was taken to hospital, resulting in a significant change in Resident #01's health condition.

On Dec 22, 2013, Resident #01, had a witnessed fall with no evidence of injury at the time of the fall.

On December 23, 2013, it was noted that the resident had pain and bruising to the right lower leg. Resident #01 was transferred to hospital for assessment and was diagnosed with bilateral fractures to both ankles. As such, this resulted in a significant change in the resident's health condition.

The Director was informed of the transfer to hospital due to injury on December 30, 2013, 6 business days after the occurrence of the incident. [s. 107. (3.1) (b)]

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**Issued on this 13th day of March, 2014**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

Colette Asselin, Inspector # 134