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: August 9, 2023	
Inspection Number: 2023-1070-0005	
Inspection Type: Critical Incident System	
Licensee: Carlingview Manor Operating Inc.	
Long Term Care Home and City: Carlingview Manor, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.08.11 11:31:49 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 12-14, 17-21, 2023.

The following intake(s) were inspected in this Critical Incident (CI) inspection:

Alleged staff to resident abuse:

- Intake:#00087632 - CI #2420-000019-23
- Intake #00087769 - CI #2420-000020-23
- Intake #00087770 - CI #2420-000021-23
- Intake #00090157 - CI #2420-000026-23
- Intake #00090734 - CI #2420-000029-23
- Intake #00091368 - CI #2420-000030-23

Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status:

- Intake #00090733 - CI #2420-000028-23
- Intake #00091877 - CI #2420-000031-23

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

Falls Prevention and Management
Infection Prevention and Control

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 (1) (c)

The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

Specifically, the resident's plan of care document and kardex did not provide information related to resident's right arm weakness as a result of a recent stroke.

The resident's written plan of care indicates resident required two-person assistance for all personal care and the kardex incorrectly indicates that the resident requires extensive assistance with one person.

An interview with the ADOC confirmed that the resident's care requirements are not consistent in the plan of care and required updating.

Failure to have clear and consistent documentation for staff puts the resident at risk of receiving improper care.

Sources: The resident's health care records, interview with ADOC and other staff. [720492]

WRITTEN NOTIFICATION: Plan of care - 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)

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

Rationale and Summary

Review of the resident's plan of care included interventions for the resident related to being a falls risk including requiring support for all transfers from the wheelchair and one to two staff assistance for bed mobility.

Review of an investigation form noted that a PSW was interviewed by management and confirmed that in May 2023, the resident was asked to stand up independently by PSW and resident's transfer status was not reviewed prior to providing care. Additionally, the PSW confirmed that the resident received thickened fluids without confirming or reviewing the resident's plan of care.

PSW also stated that they did not review the resident's transfer status prior to transferring the resident during care.

An interview with the Interim Executive Director confirmed that the PSW should have reviewed the resident's plan of care prior to providing care.

Failure to review the resident's transfer and mobility statuses and dietary requirements prior to providing care puts the resident at risk of harm.

Sources: The resident's health care records, Investigation Form, interviews with Interim Executive Director and other staff. [720492]

WRITTEN NOTIFICATION: Plan of care - Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in resident #001, #002 and #003's plan of care was documented as required.

Rationale and Summary

The point of care (POC) documentation for resident #001 showed that in May 2023, no documentation

was completed for care provided by staff to the resident on four day shifts between 0700-1500 hours, two evening shifts between 1500-2300 hours and two night shifts between 2300-0700 hours.

The point of care (POC) documentation for resident #002 showed that in May 2023 on a day shift between 0700-1500 hours, three evening shifts between 1500-2300 hours and two night shifts between 2300-0700 hours, no documentation was completed for care provided by staff to the resident.

The point of care (POC) documentation for resident #003 showed that in May 2023, on two evening shifts between 1500-2300 hours and three night shifts between 2300-0700 hours, no documentation was completed for care provided by staff to the resident.

The DOC and Interim Executive Director confirmed in interviews that documentation is required by PSW's in Point of Care (POC) for all care provided to residents.

Failure to document the care provided results in a risk to residents as staff would not be aware of when and what care was provided to the resident.

Sources: Residents' plans of care including POC, interviews with the Interim Executive Director, DOC and other staff. [720492]