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: May 9, 2024
Inspection Number: 2024-1070-0002
Inspection Type: Complaint Critical Incident Follow up
Licensee: Carlingview Manor Operating Inc.
Long Term Care Home and City: Carlingview Manor, Ottawa

Lead Inspector Linda Harkins (126)	Inspector Digital Signature Linda Harkins Digitally signed by Linda Harkins Date: 2024.05.09 15:46:53 -04'00'

Additional Inspector(s) Lisa Cummings (756)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 24, 25, 26, 30, 2024 and May 1, 2, 3, 7, 8, 9, 2024
The inspection occurred offsite on the following date(s): May 2, 2024

The following intake(s) were inspected:

- Intake: #00107230 - Complaint related to resident's rights, medications and complaint process
- Intake: #00109096 - Complaint related to allegation of neglect
- Intake: #00110791 - Critical Incident (CI) #2420-000014-24 related to an allegation of physical abuse staff to resident

- Intake: #00110819 - CI #2420-000013-24 related to an allegation of physical abuse resident to resident
- Intake: #00110869 - CI #2420-000015-24 related to an allegation of physical /verbal abuse resident to resident
- Intake: #00110919 and Intake: #00113884 - Complaint related to furnishings, the complaint response process, falls, medication administration, weight loss, and the plan of care
- Intake: #00111077 - Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 1. i.
- Intake: #00111807 - CI #2420-000017-24 related to the use of glucagon with transfer to hospital

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1070-0001 related to O. Reg. 246/22, s. 12 (1) 1. i. inspected by Lisa Cummings (756)

The following Inspection Protocols were used during this inspection:

Continence Care
Housekeeping, Laundry and Maintenance Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: 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)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when there was a change in the resident's food intake. The Food Service Supervisor identified the resident had inadequate food intake on a specific month in 2024, and referred to the Registered Dietitian (RD) for reassessment. Two weeks later, the resident's weight monitoring showed a decrease in weight. Two weeks after this, the resident's family member brought forward concern to a Registered Practical Nurse (RPN) regarding the resident's decrease in appetite and a second referral was sent to the RD for reassessment. The resident was then reassessed by the RD at the end of the month.

Sources: Nutrition Assessment, Dietitian Referrals, Progress notes, interviews with the Food Service Supervisor, Registered Dietitian and a Regional Manager.
[756]

WRITTEN NOTIFICATION: Care Conference

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 30 (1) (a)
Care conference
s. 30 (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker, if any;

The licensee has failed to ensure that an annual interdisciplinary care conference was held for a resident.

Sources: Resident healthcare record, and Interviews with the Resident Services Coordinator.
[756]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked,

The licensee has failed to ensure that the medication cart was locked. On a specific day in April 2024, a medication cart was observed to be left unattended and unlocked in front of the nursing station while several residents were sitting in the adjacent dining room.

Sources: Observation and interview with the RPN.
[126]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 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).

1) The licensee has failed to ensure that a specific medication was administered to a resident in accordance with the directions for use specified by the prescriber. As per physician order, the medication was prescribed for the resident and was to start at the beginning of the month. The Medication Administration Record was reviewed for that month, and it was noted that the medication was not administered as prescribed on three occasions.

Sources: Interviews with Assistant Director of Care (ADOC), RPNs and the Medication Administration Record.
[126]

2) The licensee has failed to ensure that a medication was administered to a resident as directed by the prescriber.

Sources: Physician orders, Progress notes, Interview with an RPN.
[756]

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