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

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Original Public Report

Report Issue Date: October 9, 2024
Inspection Number: 2024-1070-0007
Inspection Type: Complaint Critical Incident
Licensee: Carlingview Manor Operating Inc.
Long Term Care Home and City: Carlingview Manor, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7, 8, 9, 2024

The following intake(s) were inspected:

- Intake: #00126726 - 2420-000055-24- Fall of resident resulting in injuries with a change in condition.
- Intake: #00126916 - IL-0131312-OT- Complainant with concerns regarding resident care and medication administration.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

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)
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 clear direction was provided to staff and others who provide direct care to a resident. Specifically, the licensee has failed to ensure that staff were provided clear direction on approaches to be used for a resident's medication administration related to responsive behaviours and medication texture.

Sources:
A resident's electronic chart;
Observation of a medication administration to a resident;
Interviews with a Registered Practical Nurse (RPN), Assistant Director of Care (ADOC), and the Director of Care (DOC).

WRITTEN NOTIFICATION: Plan of care

NC #002 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 a resident's care, as set out in the plan of care, was provided to the resident as specified in the plan. Specifically, a Personal Support Worker (PSW) failed to ensure that a resident's personal assistance service device (PASD), as a fall prevention strategy, was applied to a resident at the time of a fall.

Sources:
A resident's care plan;
Interviews with a PSW and an ADOC.

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care as set out in a resident's plan of care was documented. Specifically the licensee has failed to ensure that a resident's hourly rounding, as part of their fall prevention strategies, was documented as specified in their plan of care.

Sources:
Review of a resident's electronic and paper chart;

Interviews with a PSW and an ADOC.

WRITTEN NOTIFICATION: Medication management system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the home's medication administration procedure included in the home's medication management system.

In accordance with Ontario Regulation 246 / 22 s. 11 (1) b., the licensee is required to develop written policies and protocols for the medication management system to ensure the accurate dispensing and administration of medications, and ensure they are complied with.

Specifically, an RPN did not comply with the licensee's "LTC-Medication Administration" procedure CARE13-O10.01, revised March 2024, when they did not keep medications in their original packaging until the time of administration and that they prepared medications in advance of administration.

Sources:
Observation of a medication administration;
Interviews with an RPN, Registered Nurse (RN) , an ADOC, and the DOC;

LTC-Medication Administration procedure CARE13-O10.01 revised March 2024.