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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2016	2016_288549_0025	013443-16	Resident Quality Inspection

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

RENA BOWEN (549), MICHELLE JONES (655), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 7, 8, 9, 2016

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping Aides, Program Manager for Recreation and Leisure , President of the Residents' Council, President of the Family Council and the Administrator.

The inspector (s) reviewed resident health care records, toured resident care areas, observed a medication administration pass, infection control practices, staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 33.(3) of the Act in that the licensee failed to ensure that a personal assistive service device (PASD) is used to assist a resident with routine activity of living only if the use of the PASD is included in the plan of care.

A. Inspector #138 observed resident #007 in bed with 4 quarter bed rails in the up position. The unit RN indicated to Inspector #138 that the bed rails were not a restraint and agreed that the bed rails for resident #007 were a PASD after discussion with the Inspector. The Inspector spoke with PSW #107 and PSW #109 regarding resident #007 and the use of bed rails for this resident. Both PSWs stated that resident #007 was physically unable to get out of bed independently but that 4 bed rails were used as a safety measure for falls prevention and for repositioning. PSW #107 further stated that the resident would not be able to release the bed rails.

The Inspector reviewed the plan of care (as defined by the home) for resident #007 and noted that the plan of care did not outline the use of bed rails for the resident. The Inspector spoke with RN #108, the unit nurse, regarding this observation. RN #108 stated that use of bed rails should be captured in the resident's plan of care but further stated that 4 bed rails were not necessary for resident #007 as this resident had other falls prevention measures in place. RN #108 stated that she would follow up and clarify the use of bed rails for resident #007 as well as updating the plan of care regarding the use of bed rails.

B. Inspector #655 observed resident #018 in bed with 2 quarter bed rails in the up position. The Inspector spoke with PSW #110 regarding resident #018 and the use of bed rails for this resident. PSW #110 indicated that resident #018 was physically unable to get out of bed independently but that the two quarter bed rails were used for falls prevention and turning. PSW #110 further indicated that resident #018 would not be able to release the bed rails.

Inspector #655 reviewed the plan of care for resident #018 and noted that the plan of care did not outline the use of bed rails for resident #018. The Inspector spoke with RN #100 regarding this observation. RN #100 indicated that the use of the bed rails for resident #018 was not in the plan of care. [s. 33. (3)]

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

Issued on this 14th day of September, 2016

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

Original report signed by the inspector.