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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 3, 2018	2018_559142_0004	014825-18	Resident Quality Inspection

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

JANET MCPARLAND (142), ANANDRAJ NATARAJAN (573)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 26, 27, 28, 29, July 3, 4 and 5, 2018.

The following intakes were completed with this Resident Quality Inspection:
-Log #004492-18 (CIR #M508-000006-18), #004406-18 (CIR #M508-000005-18), #005738-18 (CIR #M508-000007-18), #002279-18 (CIR #M508-000003-18), #005202-18 (CIR #M508-000009-18) and #008733-18 (CIR #M508-000013-18) related to falls that resulted in injuries
-Log #011586-18 (CIR #M508-000017-18) related to unplanned evacuation
-Log #008579-18 complaint related to refusal of application for admission
-Log #016093-18 complaint related to air temperatures in the Home
-Log #009281-18 complaint related to alleged abuse/neglect

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of Residents' Council , the Manager of Recreation and Leisure, Housekeeping Aides, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitians (RD), RAI-MDS co-ordinator, Social Worker, the Program Manager of Resident Care (PMORC), the Program Manager of Personal Care (PMOPC), the Manager of Hospitality Services (MHS) and the Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system is available in every area accessible by the residents.

On June 26, 2018, Inspector #573 observed that the West Carleton and Nepean unit dining rooms were not equipped with a resident-staff communication and response system (Call Bell System).

On June 28, 2018, Inspector #573 observed both the West Carleton and Nepean unit dining rooms with the home's Manager of Hospitality Services (MHS). The MHS indicated to the inspector that both the dining rooms areas are accessible to residents at all times. The MSS confirmed to Inspector #573 that there was no resident-staff communication and response system in the West Carleton and Nepean unit dining rooms. Further, the MSS stated to Inspector #573 that they will discuss with the home's system provider regarding the process for installing a resident-staff communication and response system in the above identified resident dining rooms. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person

who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device.

In accordance with O.Regulation 79/10, s.110(2), the licensee shall ensure that where there is a physical device in use as a restraint, that staff monitor the resident every hour in addition to a release and reposition at least every two hours.

On June 28, 2018, Inspector #573 observed resident #002 was sitting in a wheelchair with a front closing lap belt applied.

A review of resident #002's plan of care indicated the use of wheelchair lap belt as a restraint. Inspector #573 reviewed resident #002's health care records for the restraint which included the Substitute Decision Maker's consent and a corresponding physician's order for the use of wheelchair lap belt as a restraint.

During an interview with PSW #108 on June 28, 2018, it was indicated to Inspector #573 that they document on the Restraint and Repositioning Monitoring Record every application and removal of resident #002's lap belt restraint and repositioning of the resident.

On June 28, 2018, Inspector #573 and RN #105 reviewed the PSW records for resident #002's restraint documentation, for identified dates in the month of June 2018. The Restraint and Repositioning Monitoring Record for June 2018 had no documentation for repositioning on identified days in June 2018. There was no documentation on identified dates in June 2018 related to resident's response to the restraint. Further, there was no documentation on identified dates in June 2018 related to monitoring, application and removal of the lap belt restraint.

During an interview on June 28, 2018 with the Program Manager of Personal Care (PMOPC), it was indicated to the inspector that the Personal Support Workers (PSWs) are responsible for documenting the application of the lap belt restraint, the removal of the restraint, repositioning of the resident and the hourly monitoring of the resident. The PMOPC and Inspector #573 reviewed resident #002's Restraint and Repositioning Monitoring Record for June 2018. The PMOPC agreed with the inspector that for resident #002 the application, monitoring, resident's response, repositioning and release of the lap belt was not documented for the above identified dates. [s. 110. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented as follows: the person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning; and the removal or discontinuance of the device, to be implemented voluntarily.

WN #3: 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. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of movement and which the resident is unable to physically or cognitively remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent has been obtained and documented from the resident or by the resident's substitute decision maker.

On June 26 and 29, 2018, resident #005 was observed seated in a wheelchair with a table top.

On June 29, 2018, Inspector #573 spoke with PSW #112, who indicated that PSW staff applied the table top for resident #005. Further, PSW #112 stated that resident was cognitively and physically incapable of removing the table top at all times. Inspector #573 reviewed resident #005's care plan, which identified the use of the table top as a PASD for the resident.

On June 29, 2018, during an interview with Inspector #573, RN #100 indicated that the wheelchair table top was used to assist with resident #005's positioning and comfort. The RN indicated to the inspector that the table top was used as a PASD. Further, RN #100 indicated that resident #005 was cognitively incapable of removing the wheel chair table top on their own.

Inspector #573 reviewed resident #005's health care record with RN #100 and there was no consent that was obtained and documented regarding the use of wheel chair table as PASD either from the resident or from the resident's SDM. [s. 33. (4) 4.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.
Resident #013 has specific medical diagnoses.
On a specified date, a physician order was received to hold resident #013's identified medication, and to reassess on a specified date. On the specified date, the physician indicated on the physician order review form and in the progress notes to continue with the identified medication. On a specified date, it was discovered that the identified medication had not resumed as ordered by the physician. Resident #013 did not receive the identified medication for three days. Upon identifying the error, registered nursing staff notified the on-call physician and an order was received to re-start the medication.
In an interview with RN #105, it was confirmed that resident #013 missed three doses of the identified medication as prescribed by the physician.
Resident #013's health record was reviewed and there was no evidence of any adverse effects to the resident as a result of the medication incident. [s. 131. (2)]

Issued on this 15th day of August, 2018

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

Original report signed by the inspector.