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 prévue 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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 05, 2019	2018_779641_0040 (A1)	011246-18, 011354-18, 011680-18, 012512-18, 016356-18, 018682-18, 019483-18, 022343-18, 024392-18, 026662-18, 027645-18, 027850-18, 028095-18, 028705-18, 029262-18, 030528-18	Critical Incident System

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

Amended by CATHI KERR (641) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

In s.114.(2) Paragraph 4, the second time resident #005 was mentioned, it was written as resident #004. This was corrected in the amendment to read resident #005.

Issued on this 5 th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by CATHI KERR (641) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 5, 11, 12, 13, 14, 17, 18, 19, 20, 2018, January 2, 3, 4, and 7, 2019

The following critical incident intake logs were inspected: Log #011246-18 - CIS #M508-000015-18, #018682-18 – M508-000027-18, #019483-18 – M508-000028-18, #028705-18 – M508-000043-18, #030528-18 – M508-000045-18 related to a resident having fallen resulting in an injury; Log #011354-18 – M508-000016-18, #011680-18 – M508-000018-18, #016356-18 – M508-000023-18, #024392-18 – M508-000032-18, #026662-18 – M508-000037-18, #027645-18 – M508-000041-18, #028095-18 – M508-000042-18 related to alleged abuse or neglect of a resident; Log #022343-18 – M508-000030-18, #027850-18 – M508-000040-18 related to a missing controlled substance; Log #012512-18 – M508-000019-18 related to a resident sustaining an injury; and Log #029262-18 – M508-000044-18 related to the door access control system malfunctioning.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Managers of Resident Care (PMRC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), and residents.

During the course of the inspection, the Inspector reviewed the residents' health care records, staff to resident and resident to resident interactions, policies and procedures related to Falls Prevention, Medication Management System and Abuse and Neglect, and Critical Incident System reports (CIS) and relevant

licensee investigation notes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **3 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. 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.

An inspection was conducted in relation to intake log #018682-18 and critical incident #M508-0000-27-18, which indicated that when left unattended, resident #001 fell, sustaining an injury.

During an interview with Inspector #641 on a specified date, RN #102 indicated that resident #001 was at risk for falls as the resident would attempt to get up independently if left unattended. Falls prevention strategies were implemented which included that the resident was not to be left alone while being toileted. RN #102 specified that at the time of the fall, the staff had left the resident unattended and the resident fell, causing an injury.

Inspector #641 reviewed the resident's health care record, including the resident's care plan. The care plan indicated that the resident was not to be left unattended during toileting.

During an interview with Inspector #641 on December 17, 2018, Program Manager of Resident Care (PMRC) #112 indicated that after interviewing the staff involved, PSW #124 had left the resident unattended. The PMRC specified that the resident's care plan clearly indicated that the resident was not to be left unattended when being toileted.

The Inspector did not have an opportunity to interview PSW #124.

The licensee failed to ensure that the care set out in the plan of care for resident #001, had been provided to the resident as specified in the plan. [s. 6. (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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

An inspection was conducted in relation to intake log #011246-18 and critical incident #M508-000015-18, which indicated that resident #003 had fallen on a specified date and not received a post-fall assessment.

During an interview with Inspector #641 on December 13, 2018, PSW #109 indicated that during the early morning rounds, the PSW and PSW #110 found resident #003 had fallen. The two PSW's notified RN #108. PSW #109 indicated that the policy indicated that the resident was not to be moved until the registered nursing staff had completed an assessment. PSW #109 advised having checked on the resident frequently to assure the resident was okay, comfortable and not in pain.

During an interview with Inspector #641 on December 14, 2018, PSW #111 indicated being notified by PSW #109 that resident #003 had fallen and had not received an assessment by RN #109. The resident was lying on the fall mat with

pillows and blanket for comfort. PSW #111 advised that the two PSW's did an assessment of the resident and then got the resident up into a chair.

During an interview with Inspector #641 on December 13, 2018, RN #108 indicated having worked on the night of the incident and being told by the two PSW's that resident #003 was on the floor. RN #108 advised having assessed the resident prior to the fall but not doing an assessment of the resident after the fall. RN #108 indicated having discussed the incident with a colleague, and was told that an incident report needed to be filled out if the incident wasn't observed.

During an interview with Inspector #641 on December 17, 2018, the Program Manager of Resident Care (PMRC) #112 indicated that on the day of the incident, PSW #111 advised the PMRC that resident #003 had been lying on the floor and that PSW #109 had reported this to RN #108 at that time. PSW #109 had made the resident comfortable and had monitored the resident. PMRC #112 advised the Inspector that RN #108 had reported having done an assessment of the resident, but that the assessment had been completed earlier in the night prior to the fall. The PMRC advised that the RN was aware that the resident was on the floor and had not documented this clearly or accurately in the resident's progress notes and had not completed an assessment or incident note related to the fall.

During an interview with Inspector #641 on January 2, 2019, RN #121 indicated that when a resident fell, a registered nursing staff would immediately do an assessment of the resident prior to the resident being moved, then do a post fall assessment and a progress note to document what had happened and what was done for the resident as per their policy.

Inspector #641 reviewed the licensee's Falls Prevention Program Policy, which indicated on page 1, Program Objectives #2, that "100% of residents who have fallen are assessed and the post fall assessment is documented where the condition or circumstances of the resident requires."

The licensee failed to ensure that resident #003 was assessed and that a post-fall assessment was conducted. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

(A1)
1. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with. r.8(1)(b)

The licensee failed to ensure that written policies and protocols are developed for medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A critical incident was submitted to the Director on a specified date indicating that a controlled substance medication for resident #005 was noted to be missing when the controlled substance count was completed by two registered nursing staff at 2300 hours that evening.

Resident #005 was ordered a specified controlled substance. During the specified evening, resident #005 was given one dose of the medication by

Registered Practical Nurse (RPN) #113 at 1600 hours and no other doses were given. The controlled substance count had been correct at 1500 hours and when the RPN went to sign for the medication on the controlled substance sheet at 2200 hours, it was noted that a pill was missing. The medication cart and the medication room were searched and the pill wasn't found. Police were notified of the missing controlled substance.

During an interview with Inspector #641 on December 17, 2018, the Program manager of Resident Care, (PMRC) #112 indicated having interviewed (RPN) #113 who had worked the 1500 to 2300 hour shift and had dispensed the medications on that unit. The RPN had indicated to the PMRC having not documented giving the 1600 medications until 2200 hours, so had not noticed that the medication was missing until then.

During an interview with Inspector #641 on December 20, 2018, RPN #117 indicated that when giving any medication, including a controlled substance, the nurse must sign that it was given, immediately after. The RPN specified that signing for the medication could not wait until the end of the shift because if it wasn't documented immediately, another nurse could give that resident another dose of the medication when they were off on break.

Inspector #641 was unable to interview RPN #113. Multiple messages were left for the RPN to contact the inspector.

Inspector #641 reviewed the licensee's Medication Administration Policy and Procedures #345.03, which indicated on page 3, "Document legibly on the MAR following medication administration."

During an interview with Inspector #641 on December 20, 2018, Program Manager of Resident Care (PMRC) #107 indicated that the expectation of the home related to medication administration was that the registered nursing staff would sign for a medication as soon as it was given and not later in the shift.

The licensee failed to ensure that their written policy for medication management system, to ensure the accurate administration of all drugs used in the home, was complied with. [s. 114. (2)]

Issued on this 5 th day of February, 2019 (A1)

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

Original report signed by the inspector.