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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_730593_0013	002948-19, 006359-19	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

GILLIAN CHAMBERLIN (593)

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): April 29, May 1 - 2, 2019.

Two Critical Incident (CIS) intakes were inspected: log #006359-19 related to alleged neglect of a resident and log #002948-19 related to an incident for which a resident was taken to hospital and resulted in a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nursing staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, resident's environment, staff to resident interactions, reviewed resident health care records and licensee investigation records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term

Care (MOHLTC), reporting a fall of resident #002 during care. It was reported in the CIS that resident #002 was being washed in bed, PSW #105 stepped away from the bed to get a cloth and the resident turned and fell out of bed. Resident #002 sustained injuries to a specific area. Resident #002 was sent to hospital for assessment. Resident #002 returned the same day from hospital with a diagnosis of fractures to a specific area.

A review of resident #002's health care record, found the following:

Progress note: resident was being washed in bed. PSW turned and made one step away from the bed when resident turned and fell out of bed. Resident hit the bedside table. Multiple injuries sustained. Resident will be sent to the ER. RN #106

Care Plan- Resident #002 will remain safe on their bed. Resident #002 has low to floor bed and bed mats on both sides of the bed. Resident #002 will have pillows on either side to support while in bed.

During an interview with Inspector #593, May 02, 2019, PSW #105 indicated that they were providing care to resident #002, when they stepped away to reach the residents underwear and the resident flipped over and fell off the bed. PSW #105 further indicated that the bed was raised and the floor mats removed while providing care. After care is provided, the bed is lowered and the floor mats are put back in place. PSW #105 said that the usual practice while providing care in bed is to have everything within reach.

During an interview with Inspector #593, May 02, 2019, RN #106 indicated that PSW #105 was providing care to resident #002 and they stepped away to grab something from the dresser and the resident fell out of bed. RN #106 indicated that the expectation when providing care in bed was that staff are not to turn their backs on a resident. They are to complete the care and then lower the bed back to it's lowest position.

During an interview with Inspector #593, May 02, 2019, DOC #104 indicated that the expectation while providing care in bed is that the resident should not be left alone, even for a second, and that if the staff did have to leave a resident, they should lower the bed right to the floor or have another staff member stand beside the resident.

As such, the licensee has failed to use safe positioning techniques when providing care to resident #002, resulting in a fall where the resident sustained multiple injuries. (log #002948-19) [s. 36.]

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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the care set out in resident #001's plan of care, was provided to the resident as specified in the plan.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged neglect of resident #001 by night shift staff. It was reported in the CIS that resident #001 was found in the morning, naked and wrapped in a comforter that was saturated with urine. The bed was also soaked with a large amount of urine and when the PSW went to assist, the resident slipped on urine and was lowered to the floor.

A review of resident #001's documented plan of care found the following intervention documented under several titles, walk in room, walk in corridor, locomotion on unit and locomotion off unit:

• One staff to ensure that walker is within reach at all times and resident is using.

Under the falls prevention title, the following intervention was documented:

• Ensure their 4WW is always within reach- remind them to use it or retrieve it for them. Will often forget to use it.

During an interview with Inspector #593, May 01, 2019, PSWs #101 and #102 indicated that they found resident #001 in their room. naked, soaking wet and cold. The PSWs explained that they tried bringing the resident to the bathroom but the floor was wet and they slipped on the wet floor. PSW #102 further indicated that the walker was not in the resident's room and they could not leave the resident to find it as the resident was naked. PSW #102 said that later they found the residents walker in the dining room, adding, I don't know what happened on evenings or nights, but it was not in the residents room. PSW #102 also indicated that resident #001 will sometimes toilet themselves and required their walker for ambulation.

During an interview with Inspector #593, May 1, 2019, RPN #103 indicated that they were working day shift and when the two PSW's went to get resident #001 up, they were naked, saturated and shivering. The walker was not in their room and the PSWs assisted the resident to the bathroom and the floor was wet with urine, the resident slipped and the PSWs lowered the resident to the floor. RPN #103 further indicated that the walker should be in the resident's room after they go to bed, in case they wake up and want to ambulate somewhere, which resident #001 often does.

During an interview with Inspector #593, May 01, 2019, DOC #104 indicated that the goal is to keep walkers within reach so that they are accessible to residents. When the residents go to bed, if they get up on their own, they can be safe. DOC #104 further indicated that resident #001 will sometimes get up and toilet themselves.

Resident #001 was known to self-ambulate and required their walker to do so safely. Resident #001 was found naked, wet with urine and complaining of being cold when the day shift started. PSW staff were assisting the resident to the bathroom to be washed and dressed. however their walker was not available and the resident slipped on the wet floor. As such, the licensee has failed to ensure that the care outlined in the plan of care was provided to resident #001. (log #006359-19) [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report. 3. i. what care was given or action taken as a result of the incident, and by whom.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged neglect of resident #001 by night shift staff. It was reported in the CIS that resident #001 was found in the morning naked, wrapped in a comforter that was saturated with urine, the bed was also soaked with a large amount of urine and when the PSW went to assist, the resident slipped on urine and was lowered to the floor.

The CIS initially submitted did not include the care that was given or action taken as a result of the incident. The CIS was amended at a later date, however this information was still not provided. (log #006359-19) [s. 104. (1) 3.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report. 4. i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged neglect of resident #001 by night shift staff. It was reported in the CIS that resident #001 was found in the morning naked, wrapped in a comforter that was saturated with urine, the bed was also soaked with a large amount of urine and when the PSW went to assist, the resident slipped on urine and was lowered to the floor.

The CIS initially submitted did not include the care that was given or action taken as a result of the incident. The CIS was amended at a later date, however this information was still not provided. (log #006359-19) [s. 104. (1) 4.]

Issued on this 23rd day of May, 2019

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

Original report signed by the inspector.