Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 31, 2020	2020_593573_0001	020830-19, 021646-19, 000447-20, 000719-20	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

ANANDRAJ NATARAJAN (573)

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): January 9 -10, and 13 - 17, 2020.

The following critical incident intake logs were inspected:
-Log #020830-19 related to a missing controlled substance.
-Log #021646-19 related to resident to resident alleged physical abuse.
-Log #000447-20 related to an unexpected death of a resident.
-Log #000719-20 related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI- Coordinator, the Program Manager of Personal Care (PMOPC) and the Program Manager of Resident Care (PMORC). In addition, the inspector reviewed resident health care records, observed the provision of care and services to residents, staff to resident interactions, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (3) The licensee shall ensure that the care plan sets out,
(a) the planned care for the resident; and O. Reg. 79/10, s. 24 (3).
(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's 24- hour admission written plan of care set out clear direction to staff and others who provide direct care to the resident, specifically in relation to resident #005's bladder continence /toileting needs and transfers.

Resident #005 was admitted to the home with multiple diagnosis. A review of resident #005's initial assessment on a specified date for bladder continence, indicated that resident #005 was frequently incontinent. Furthermore, the assessment indicated that resident #005 required extensive assistance with two-person physical assist for the toileting. For the mode of transfers, it indicated that resident #005 was transferred mechanically.

On January 15, 2020, Inspector #573 spoke with PSW #101, they indicated that resident #005 was incontinent of bladder and uses the toilet in the unit's shower/ tub room. The PSW indicated that resident #005 was transferred to the toilet with two-person physical assist nor with the use of sit to stand mechanical lift. The PSW stated that resident #005 does not have specified toileting routine nor a schedule. Further, the PSW indicated that the resident will request the staff member, when they required to go to the toilet.

On January 16, 2020, Inspector #573 spoke with PSW #102, they indicated that resident #005 was incontinent of bladder. The PSW stated that the resident was toileted by using commode in the resident's room. Further, the PSW indicated that they will use the mechanical lift for the resident's transfers.

On January 16, 2020, Inspector #573 spoke with PSW #103, they indicated that resident #005 was incontinent of bladder. The PSW stated that in their shift, resident #005 was not toileted in the commode nor in the unit's shower/ tub room. Further, the PSW stated that resident #005 continence care was provided in the bed.

On January 16, 2020, RN #104 provided documents related resident #005's 24 - hour admission written plan of care in place to the inspector. Inspector #573 reviewed resident #005's 24-hour admission written plan of care in place for urinary continence/ toileting. It indicated that resident #005 was incontinent for the bladder and for the toileting routine, it indicated that the resident was continent with a specified appliances. For the resident's transfers, it indicated mechanical lift for bed to chair transfer. Resident #005's kardex for the toileting was reviewed and that indicated the resident's attends are changed in bed. The Kardex indicated that when the resident is in their wheelchair, they were able to toilet in the tub room. Further, it indicated that resident able to stand using the rail in the tub

room.

Inspector spoke with RN #104, they stated to the inspector that resident #005 was not on a specified appliances for bladder continence. Regarding resident #005's toileting and transfer, the RN stated that staff member will toilet the resident in the unit's shower/ tub room with two to three-person physical assist transfer nor with the sit to stand mechanical lift. Further, the RN stated that resident #005 does not have a specified toileting routine nor a schedule.

Inspector #573 reviewed resident #005's 24-hour admission written plan of care in place in the presence of the RAI -coordinator. Upon review, the RAI -coordinator indicated that the 24-hour written plan of care did not provide clear directions to staff regarding resident #005's bladder continence/toileting needs and transfers. (Log #000719-20) [s. 24. (3)]

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 resident #005's 24 hour- admission written plan of care set out clear direction to staff and others who provide direct care to the resident, 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.

A critical incident report was submitted to Ministry of Long-Term Care on a specified date, related to an unexpected death of resident #001.

On January 09, 2020, Inspector #573 reviewed the written plan of care in place for resident #001. The written plan of care indicated that resident #001 had history of falls and included interventions to manage the risk of fall for the resident.

Inspector #573 reviewed resident #001’s progress notes for an identified month, it was documented that the resident had three fall incidents. Furthermore, two fall incidents were noted on the same day on a specified shift.

On January 13, 2020, Inspector #573 and the RAI-coordinator reviewed resident #001’s health care record, that indicated no post-fall assessment using a clinically appropriate tool specifically designed for falls was done for the resident’s three fall incidents in the identified month. The RAI- coordinator stated that for every resident’s fall incident, the registered nursing staff should complete a post fall assessment in the Medicare – e assessment.

During an interview with Inspector #573, the Program Manager of Resident Care (PMORC), they indicated that when a resident has fallen, the registered nursing staff would assess the resident, then should complete a post fall assessment using a clinically tool specifically designed for falls in the Medicare – e assessment as per the licensee fall’s prevention policy/ program.

The licensee has failed to ensure that resident #001 had a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (Log #000447 -20) [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.

Issued on this 3rd day of February, 2020

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

Original report signed by the inspector.