

**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
Feb 25, 2020	2020_559142_0003	001498-20, 002733-20	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

JANET MCPARLAND (142)

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): February 19, 20, 21, and 24, 2020.

The following critical incident intake logs were inspected:

-Log #001498-20 (CIR# M508-000005-20) related to an unexpected death of a resident.

-Log #002733-20 (CIR# M508-000007-20) related to alleged neglect of a resident.

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

The following Inspection Protocols were used during this inspection:

Falls Prevention

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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 has 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.

Critical incident report #M508-000005-20 was submitted to Ministry of Long-Term Care on a specific date related to an unexpected death of resident #001.

In a review of resident #001's health record, the resident was identified at risk for falls and was on the falls risk program.

Resident #001's progress notes were reviewed for a specific period of time and it was noted that the resident had a fall on identified dates. It was further noted in a review of resident #001's health record, there was no post fall assessment tool completed after each of the identified fall incidents.

During separate interviews with Inspector #142, RPN #109, RN #110, Program Manager of Resident Care #101 and Program Manager of Personal Care #102, they indicated that for every resident fall incident, the registered nursing staff would assess the resident, and complete a post fall assessment using a clinically tool specifically designed for falls.

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 #001498-20). [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 26th day of February, 2020

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

Original report signed by the inspector.