Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 29, 2023
Inspection Number: 2023-1534-0006
Inspection Type: Critical Incident System
Licensee: City of Ottawa
Long Term Care Home and City: Carleton Lodge, Nepean

Lead Inspector	**Inspector Digital Signature**
Emily Prior (732)	Emily Prior Digitally signed by Emily Prior Date: 2023.07.14 09:26:13 -04'00'

Additional Inspector(s)
Lisa Kluke (000725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00086455 (IL-12505-AH/M508-000011-23) related to a medication incident.
- Intake: #00086564 (M508-000012-23) related to choking episode of a resident.
- Intake: #00089504 (M508-000013-23) related to falls prevention and management.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed after sustaining an injury.

Rationale and Summary:
On a specified date, the Long-Term Care home reported a Critical Incident Report to the Director regarding a resident being sent to the hospital and returning with a significant change in their care.

The resident's progress notes indicated the resident returned to the home and later the hospital provided their recommendations for interventions for the resident based on their injury.

The resident's current care plan/kardex had been reviewed five days earlier, however no indication other than diagnoses identified this resident to have this injury. No interventions in the plan of care were documented.

On this same date, RN #108 indicated upon review of the resident's plan of care, that no interventions related to care required for this injury were added as required.

On this same date, RPN #107 indicated updates to the residents plan of care are completed by the RN's in charge.

On this same date, approximately one hour later, an updated plan of care for the resident was noted in the home's electronic documentation system completed by RN #108. Inspector reviewed that the plan of care was updated and the appropriate interventions related to the resident's injury were

documented.

Sources: Interview with RPN #107 and RN#108, observations of resident, review of CIR, and record review of resident's progress notes and plan of care.
[000725]

Date Remedy Implemented: June 22, 2023

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