



**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 le Loi de 2007 les foyers de soins de longue**

Health System Accountability and Performance  
Division  
Performance Improvement and Compliance Branch  
Division de la responsabilisation et de la performance du système de santé  
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 18, 22, 23, 2012	2012_198117_0003	Critical Incident

**Licensee/Titulaire de permis**

CITY OF OTTAWA  
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

**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**

LYNE DUCHESNE (117)

**Inspection Summary/Résumé de l'inspection**

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

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Clinical Care Coordinator, RAI MDS coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and to several residents.

During the course of the inspection, the inspector(s) reviewed several residents' health care records; observed resident care and services; reviewed two critical incident reports; reviewed the home's Fall Preventions Program, Falls Indicator Policy #360.07, revised July 2012 and the Resident Assessment for Falls Tool Policy # 315.08, revised March 2012.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

**NON-COMPLIANCE / NON-RESPECT DES EXIGENCES**



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<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>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>Legendé</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>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>
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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 subsections:

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 comply with LTCHA s. 6 (7) in that care set out in the plan of care, was not provided to a resident, as specified in the plan of care.

On an identified day in September 2012, a PSW seated the resident #3 on the toilet. As the PSW was leaving the resident's bathroom to get continence product supplies, the resident fell off the toilet. The RN #S100 stated that he/she assessed resident # 3 post-fall. The resident did not sustain any injuries.

The resident's plan of care states that the resident is at risk for falls and is not to be left unattended while on the toilet. The RN #S100 stated that the PSW had left the resident unattended while on the toilet resulting in the resident's fall. The PSW did not provide care to resident as set out in the resident's plan of care.

Issued on this 23rd day of October, 2012

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

*Lynne Duchesne # 117*