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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2013	2013_198117_0011	O-000023-13	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): June 17, 18, 19 and 20, 2013

Please note that this complaint investigation was conducted concurrently with the home's Resident Quality Inspection log #O-000362-13. There is a separate inspection report for the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager of Nursing, RAI Coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), several Personal Support Workers (PSW)and the identified resident.

During the course of the inspection, the inspector(s) reviewed the health care record of the identified resident, observed resident care, reviewed the home's internal investigation report, reviewed the home's policies # 310.04 Transfer: External Hospital and # 310.05 Transfer: Hospital Non-Emergency.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O., c. 8, s. 6 (9) (1) in that Resident #001's provision of care was not documented.

Resident #001 is identified as having frequent urinary tract infections (UTIs). The resident's November 2012 plan of care identifies that nursing staff are to monitor the resident for symptoms of UTI which include elevated temperature, changes in urinary colour, odour, frequent and urgency of urine, burning and back pain.

In November 2012, the resident was diagnosed with a UTI. Antibiotic treatment was started on a specified day in November, 2012. Urine culture and sensitivity test (urine C&S) done 10 days later was positive and a new antibiotic treatment was started. Four days after the start of the new antibiotic treatment, the attending physician prescribed a third antibiotic treatment. At the end of the third antibiotic treatment the resident's temperature was 36.6C.

Home's Program Manager of Nursing stated to Inspector #117 during a telephone conversation on June 25, 2013, that it is the home's expectation that registered nursing staff monitor resident health status after the end of an antibiotic treatment and that urine C&S is to be done 10-14 days after the end of treatment to verify the effectiveness of the antibiotic treatment. The Program manager also stated that if a resident presents signs and symptoms of possible or ongoing UTI, registered staff can do a urine dipstick test and or a urine C&S at any time. There is no documentation in Resident #001 chart related to ongoing assessment of the resident's health status between the end of the third antibiotic treatment in November, 2012, and a specified day in December, 2012, as it relates to post UTI antibiotic treatment.

During a specified evening in December, 2012, Resident #001 presented with elevated temperature and hematuria. Blood was seen by a member of the resident's family and staff members #102 and #105 to be visible and present in the resident's continence brief. There is no documentation in the resident's chart related to the presence of visible hematuria during the specified evening in December, 2012.

The on-call physician was contacted by staff member #105. A medical order was received for the immediate administration of an anticoagulant and antibiotic medication. Progress notes and medication administration records show that the medications were given as per medical orders. However, no documentation was found in the resident's chart related to the ongoing assessment of the resident's hematuria

during the rest of the specified evening, and the following night and day shifts in December, 2012. [s. 6. (9) 1.]

Issued on this 26th day of June, 2013

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

Lyne Duchesne #117