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 18, 27, 2013	2013_193150_0013	O-000362-13	Resident Quality Inspection

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

CAROLE BARIL (150), JANET MCPARLAND (142), LYNE DUCHESNE (117), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 12, 13, 14, 17, 18, 19, 20, and 21, 2013

The following inspections were also conducted in conjunction with the RQI: complaint inspection O-000023-13 (separate report), complaint inspection O-000273-13, critical incident inspection O-000201-13, critical incident inspection O -000334-13, and critical incident inspection O-000353-13.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, the President of Resident Council, President of Family Council, the Administrator, both Program Managers of Resident Care, several Registered Nurses (RN), several Registered Practical Nurses (RPN), the RAI-MDS Specialist, Nursing Support Clerk, several Personal Support Workers (PSW), the Manager of Hospitality Services, Food Services Workers (FSW), Housekeeping Supervisor, several Housekeeping Aides, the Manager Recreation and Leisure, the Maintenance Supervisor, Maintenance Staff, the Staffing Coordinator, a Program Admin Clerk, Financial Officer, the Receptionist, an Administrative Assistant, and a Social Worker.

During the course of the inspection, the inspector(s) Reviewed residents' health care records, reviewed several of the home's policy and procedure, reviewed several Critical Incident Reports, toured resident rooms, toured resident common and non common areas, reviewed the admission package, reviewed Resident Council and Family Council minutes, observed several medication passes, observed several meal and snack services, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5 in that the licensee failed to ensure that the home is a safe and secure environment for its residents.

On June 12, 2013, during the initial tour of the home, LTCH Inspector #150 observed the door to the laundry chute at the entrance of the West Carleton unit was not lock.

The inspector observed a sign on the door to the laundry chute door indicating that the door was to be locked at all times.

The door to the laundry chute was checked several time thereafter on June 12, 13, 14, 17, 2013 and the door was observed to be lock.

On June 18, 2013 at 08h45, the inspector observed the door to the laundry chute at the entrance of the West Carleton unit was not locked.

The RPN on the unit was notified and the Maintenance Supervisor came to assess the condition of the door to the laundry chute. [s. 5.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) (4) in that a resident was not provided the right to be properly fed in a manner consistent with his/her needs.

During the initial dining observation on Rideau on June 12, 2013 at the lunch meal service, LTCH Inspector #138 observed Resident #7146 sitting at a table by himself/herself in the dining room. The resident had a glass of fluid and a texture modified meal in front of him/her and was observed to finish his/her glass of fluid but was not eating his/her entrée. A few minutes later at 1:01pm the resident was observed to be pushing around his/her entrée plate with his/her hands but was not eating. The entrée did not look like as if much more that a couple of bites had been taken by the resident. The staff on the unit removed the entrée and replaced it with the alternate entrée choice along with verbal encouragement to eat. It was observed by the LTCH Inspector that the resident was not provided cutlery to accompany his/her meal when the alternate entrée was provided and the resident was without cutlery. The care plan for the resident did indicate that the resident does eat with his/her hands but that spoons are to be given to the resident with encouragement to use. The alternate entrée choice that was provided to the resident was minced meat with gravy and mashed potatoes which would be difficult for a resident to eat with their hands. Regular texture mixed vegetables including peas and carrots were also provided in the alternate entrée choice and the resident was observed to use his/her hand to feed herself a few bites of these mixed vegetables.

The resident was then observed to raise his/her empty cup to his/her lips several times and attempted to wave at staff walking by while holding his/her empty cup. No additional fluid was offered or provided to the resident.

At 1:13pm, a PSW was observed to reposition the plate on the resident's table but no cutlery was provided nor was any additional fluid to drink offered or provided.

At 1:14pm the resident was observed to eat a few pieces of vegetables using his/her hands but his/her entrée remained almost untouched until 1:28pm when is was taken away and replaced with a bowl of ice cream and a spoon. Still, no additional fluids were offered or provided. The resident was observed to eat two bites of ice cream and then at 1:30pm LTCH Inspector observed the resident dropped his/her bowl of ice cream and spoon on the floor where it stayed until 1:35pm when a PSW was observed to clean up the ice cream of the floor. The same PSW was observed to

clean up the resident and push him/her out of the dining room without offering the resident any more ice cream or any further fluids. This resident was only provided one glass of fluid during the meal service while the other residents in the dining room were offered two glasses of fluids plus their choice of a hot beverage.

In total, it was observed by the LTCH Inspector that throughout the course of the meal service the resident only had one glass of fluid, bites of entrée and two bites of ice cream.

The resident's care plan was reviewed and it stated that the resident was at a moderate nutritional risk with a goal to maintain/promote weight gain to desirable weight range of with an intervention of providing the resident a high protein diet with minced meat. A review of the resident's chart showed that the resident is not meeting this goal as the resident has experienced weight loss since December 2012 and his/her weight is now below the desirable weight range. [s. 3. (1) 4.]

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 #7146 is fed in a manner that is consistent with her needs to promote weight maintenance/weight gain to her desired weight range, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 13 in that the licensee failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Privacy curtains in a number of semi-private rooms were noted to be insufficient to enclose each bed and provide privacy to the resident. Specifically, rooms 1, 5, 32, and 36 on Rideau and rooms 5, 32, and 36 on Goulbourn. [s. 13.]

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 there are adequate privacy curtains to provide privacy in rooms that have more than one resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) (c) in that the home and furnishings are not maintained in a good state of repair.

During stage 1 of the Resident Quality Inspection, conducted on June 12 – 14, 2013, LTCH Inspector #117 and #138 observed the there was a large hole in the floor in several of the spa rooms. LTCH Inspector #138 observed a large hole at least twelve inches wide and several inches deep in front of the tub surrounding the plumbing in the Manotick spa room in Rideau. The same was observed by the inspector in the Stittsville and Richmond spa rooms on Goulbourn. LTCH Inspector #117 also observed a similar type of hole in the tub room on the west wing of Nepean.
LTCH Inspector #138 spoke with the Maintenance Supervisor who stated that he was made aware of the holes in the floor in the spa rooms and was in the process of organizing their repair. He stated that the holes have been present since the spa tubs were installed at least eighteen months to two years ago.

During stage 1 of the Resident Quality Inspection, conducted on June 12-14, 2013, LTCH Inspector #138 observed several resident bedside tables on Goulbourn were in a poor state of repair in that the top front and side edges were heavily chipped and the particle board was exposed. On June 19, 2013, LTCH Inspector #138 conducted an audit on all units of the home and observed that the bedside tables on Rideau, West Carleton, and Nepean were in satisfactory condition but that there were nineteen of twenty-five bedside tables on Goulbourn that were not in satisfactory condition. These identified bedside tables on Goulbourn were heavily chipped along the top front and side edges exposing the particle board and giving the table top a rough and porous surface. The inspector observed that one of the bedside tables in room 32 had green masking tape along all top edges that covered the chipped edges.

During stage 1 of the Resident Quality Inspection, on June 13, 2013, Inspector #138 identified on Rideau that there are sixteen wood framed dining room chairs in the dining room/lounge area all in which had heavy scarring on the legs. There were eight wood frame lounge chairs in the dining room/lounge and all eight chairs had scarred legs and arms with the wood finish worn off.
It was also noted by the inspector that there were a variety of dining room tables in the dining room but that three of the six wooden pedestal base dining room tables were are heavily scarred.
LTCH Inspector #142 also made consistent observations regarding the furnishings on Rideau of June 14, 2013.

During stage 1 of the Resident Quality Inspection, June 12 - 14, 2013, Inspector #138 identified several resident rooms on Goulbourn that had flooring that was in disrepair. On June 19, 2013, LTCH Inspector #138 completed an audit regarding the condition of the flooring on Rideau, Goulbourn, West Carleton and Nepean.
The inspector found that Gouldbourn was identified as the unit with the most flooring in disrepair. The flooring in both Stittsville and Richmond corridors in Goulbourn was observed by the inspector to be cracked on both sides of the corridor near the walls. These cracks ran the length of the corridor and in spots the cracks were wide enough that the mesh backing of the flooring was visible. In addition, six out of nine resident rooms audited on Stittsville and eight of ten resident rooms on Richmond had flooring that was not intact. Specifically, the flooring in rooms 1, 4, 6, 13, 15, and 17 on Stittsville and rooms 22, 27, 29, 30, 31, 32, 34, and 36 on Richmond were observed to have a variety of cracks, bubbles, and tears mostly found around the resident's bed. The inspector further found on that on West Carleton the flooring in the Carp hallway was also in disrepair in that it was cracked near the corridor walls. Again, as in Goulbourn, these cracks ran the length of the corridor and in spots the cracks were wide enough that the mesh backing of the flooring was visible. At the end of the corridor the inspector observed that there was a bubble in the flooring that had been covered in duct tape. Duct tape had also been used on the floor at the entrance of the West Carleton Unit to cover three linear cracks.

LTCH Inspector #138 spoke with the Maintenance Supervisor who stated that the resident rooms and areas are not routinely audited for maintenance requirements but that maintenance staff relies on guidance from unit staff for maintenance concerns. He did state that a comprehensive audit of the home has not been conducted in the past several years and one is being planned for 2013-14. [s. 15. (2) (c)]

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 the flooring on the resident units including the spa rooms, dining room/lounge furniture on Rideau, and the bedside tables on Goulbourn is in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 17 (1) (a) in that the licensee failed to ensure that communication and response system (call bell system) can be easily accessed and used by residents at all times.

On June 12 – 14, 2013, during stage 1 of the Resident Quality Inspection, LTCH Inspectors #117 and #138 collectively observed that several residents did not have access to their call bells and would not be able to engage the call bell for assistance.

Specific observations made through stage 1 were:

Resident #7120 and Resident #7159 were observed by LTCH Inspector #138 in their beds.
Both their call bell cords were observed to be wrapped around a hook on the wall at the call bell panel located on the wall off to the side of the resident's head of bed with the call bell dangling behind the night stand making it out of reach for the residents

LTCH Inspector #117 also observed the same situation with Resident #7143.

LTCH Inspector #138 observed Resident #7171 to be in his/her wheelchair which was situated at the foot of his/her bed. His/her call bell was observed to be on the floor at the head of his/her bed and not within reach.

LTCH Inspector #117 observed a similar situation in that Resident #7144 was in his/her wheelchair in his/her room and the call bell was clipped to the wall and hanging behind his/her night side table out of reach of the resident.

On June 19, 2013 during stage 2 of the Resident Quality Inspection, LTCH Inspector #138 was on Gloubourn unit mid morning and went into Resident #7133's room. The resident was observed to be sitting in his/her wheelchair in front of his/her TV. S/he asked the inspector for assistance and stated that s/he wanted to leave his/her room. It was observed by the inspector that the resident's call bell was several feet away from resident on the floor beside his/her headboard. The inspector obtained the call bell and gave it to the resident who then rang for assistance. A PSW came into the resident's room immediately and the resident was heard by the inspector to ask the PSW to help him/her leave the room. The PSW provided assistance in transporting resident.

Within a few minutes, LTCH Inspector #138 was then in Resident #7171's room. The resident was observed to be sitting in his/her wheelchair at the foot of his/her bed facing his door and looking into the hallway. The inspector observed that the resident's call bell was on his/her bed and out of reach from the resident. The inspector asked the resident if s/he would like his/her call bell and s/he stated yes. The inspector place resident's call bell further down on his/her bed within his/her reach.

Mid morning on June 20, 2013, LTCH Inspector #138 walked through Goulbourn, Nepean, and West Carleton units and found 20 residents in their rooms. Half of these residents, ten of the twenty, were observed to not have a call bell within reach.

Specifically,
Resident in Goulbourn room 22 was in a wheelchair watching TV and his/her call bell was at the head of his/her bed under the bed.
Resident in Goulbourn room 27 was in his/her wheelchair while the call bell was clipped out of reach to his/her bed.
Resident in Nepean room 38 was in his/her wheelchair in room and his/her call was hanging behind and under the nightstand.
Residents in Nepean room 28 and 37 were in their wheelchairs beside their bed and their call bells were clipped to the opposite side of the bed.
Resident in West Carleton room 26 was in his/her wheelchair and his/her call bell was attached to the bed rail out of reach.
Resident in West Carleton room 28 was in his/her room reclined in wheelchair watching TV and his/her call bell was noted to be under his/her bed.
Resident in West Carleton room 31 was in his/her wheelchair beside his/her bed and his/her call bell was on the floor under his/her bed.
Resident in West Carleton room 4 was in his/her wheelchair and his/her call bell was noted to be on his/her bed and not with in reach. [s. 17. (1) (a)]

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 the residents' call bell are placed in a manner that provides for easy access to the call bell system, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 36 in that licensee failed to use safe transferring and positioning devices or techniques when assisting residents.

Resident #2027 was recently admitted to the home with in the year. Resident was assessed upon admission as dependent on staff for all care needs due to weakness.
The Falls RAP on admission indicated that resident was a high risk for falls.
The care plan on admission identified that the resident required two or more persons to provide assistance with toileting and two person assistance for transfers.
The resident was observed by therapy staff to be leaning over in a wheelchair which was loaned to him/her by the Home. A referral to Occupational Therapy was offered to the resident's family member as the loaned chair was not the right size for the resident, but the family member declined the referral.

On a day in April 2013, one HCA was transporting resident in his/her wheelchair to the bathroom. The resident's wheelchair wheel got stuck on the floor mat that was beside the resident's bed and resident fell forward hitting his/her head on the floor sustaining an injury. Resident was transferred to hospital for assessment.
The Director of Care indicated that the resident was transported by one staff member and that the staff member did not seek the assistance of another staff member.
Resident returned to the home with a confirmed injury.

O-000334-13 [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs; 2007, c. 8, s. 78 (2)
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents; 2007, c. 8, s. 78 (2)

(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package; 2007, c. 8, s. 78 (2)
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations; 2007, c. 8, s. 78 (2)
(q) an explanation of the protections afforded by section 26; 2007, c. 8, s. 78 (2)
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, s. 78 (2) (c) in that the admission package does not include the home's policy on abuse an neglect.

Inspector #117 reviewed the home's admission package with the home's social worker on June 17, 2013 and with the home's administrator on June 19, 2013. The admission package does provide some information on zero tolerance for abuse and neglect of residents. However, the admission package does not contain a copy of the home's policy on zero tolerance for abuse and neglect [s. 78. (2) (c)]

2. The licensee failed to comply with LTCHA 2007, s. 78 (2) (d) in that the admission package does not include an explanation of the duty to make mandatory reports.

Inspector #117 reviewed the home's admission package with the home's social worker on June 17, 2013 and with the home's administrator on June 19, 2013. The admission package provides some information regarding the possibility of residents, families or volunteers to report any abuse without fear of retaliation, legal action or discharge from the home . However, the admission package does not contain any information related to the duty to make mandatory reports to the Director related to incidents resulting in harm or risk of harm to a resident such as :
- improper or incompetent treatment or care of a resident
- abuse by anyone or neglect by the licensee or staff
- unlawful conduct
- misuse or misappropriation of a resident's money
- misuse or misappropriation of funding provided to the licensee [s. 78. (2) (d)]

3. The licensee failed to comply with LTCHA 2007, s. 78 (2) (n) in that the home's admission package does not include a disclosure of non-arm's length relationships.

On June 19 2013, Inspector #117 reviewed the home's admission package and admission agreement with the home's administrator. It was noted that the admission package and admission agreement do not include any information related to a disclosure of any non-arm's length relationships that exist between the licensee and other providers who offer care, services, programs or goods to residents at the home. [s. 78. (2) (n)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. (3) in that the licensee failed to seek the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey.

The Administrator was interviewed by LTCH Inspector #138 regarding the annual satisfaction survey. While the satisfaction survey was completed yearly, the Administrator reported that the development of the satisfaction survey is done through the branch office for all four city homes and that the Family Council and Residents' Council are not involved in its development.

The President of the Resident Council was interviewed and he stated that he did not recall if the Resident's Council had input into the development of the satisfaction survey but that he had only been the president for three months.

The Manager of Recreation and Leisure was interviewed as she assists the Residents' Council. The Manager of Recreation and Leisure stated that the results of the satisfaction survey are brought to the Resident's Council for discussion but that the Residents' Council has not been involved in the development of the satisfaction survey.

The President of the Family Council was interviewed and he stated that the Family Council is made aware of the results of the satisfaction survey but that he could not recall that the Family Council has had input into the development of the satisfaction survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 129 (1) (b) in that the licensee failed to to ensure that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On June 21, 2013 Lorazepam 4mg/ml injectable (1ml), a controlled substance, was observed stored in the fridge in the locked medication room on Nepean.
On June 21, 2013 Lorazepam 4mg/ml injectable (1ml), a controlled substance, was observed stored in the fridge in the locked medication room on Rideau. [s. 129. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 224. Information for residents, etc.

Specifically failed to comply with the following:

s. 224. (1) For the purposes of clause 78 (2) (r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided for in section 78 of the Act includes information about the following:
1. The resident's ability under subsection 82 (2) of this Regulation to retain a physician or registered nurse in the extended class to perform the services required under subsection 82 (1). O. Reg. 79/10, s. 224 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 in that the home's admission package does not include information on the ability to retain a physician or a registered nurse in the extended class (RN-EC) to perform the required services.

The home's admission package was reviewed by Inspector #117 with the home's social worker on June 17, 2013. The package gives information related to the home's medical director and physicians, as well as consultations with specialists as required based on individual resident needs. However, the admission package does not provide any information related to the resident's or legal substitute decision maker's ability to retain a physician or an RN (EC) to perform the services required under subsection (1) of O.Reg. section 82 Attending Physicians and RNs (EC). [s. 224. (1) 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #901	2013_193150_0013	150

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

Issued on this 27th day of June, 2013

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

Paula MacDonald RD
J McFadden RD
Cindy Bard
Lynn Duchesne

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROLE BARIL (150), JANET MCPARLAND (142), LYNE DUCHESNE (117), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2013_193150_0013
Log No. / Registre no:	O-000362-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 18, 27, 2013
Licensee / Titulaire de permis :	CITY OF OTTAWA Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6
LTC Home / Foyer de SLD :	CARLETON LODGE 55 LODGE ROAD, R. R. #2, NEPEAN, ON, K2C-3H1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RICHARD GOURLIE

To CITY OF OTTAWA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee is to ensure that the laundry chute door located in the West Carleton unit is immediately addressed to restrict unsupervised residents access to the laundry chute at all times.

The licensee shall take immediate measures to ensure the residents' safety until the door to the laundry chute is secured.

Grounds / Motifs :

1. The licensee has failed to comply with LTCH Act, 2007, S.O. 2007,s.5, in that the door to the laundry chute on the West Carleton unit is not safe and secure.

On June 12, 2013, during the initial tour of the home mid morning, inspector #150 observed the door to the laundry chute at the entrance of the West Carleton unit, where approximately 40 long term care home residents resides, was closed but not locked and was easily opened by the inspector by pushing on the door.

Inspector observed a sign on the door of the chute indicating that the door is to be locked at all times.

The door to the chute was verified several time thereafter on June 12, 13, 14, 17, 2013 and the door was observed to be lock.

Then on June 18, 2013, at 08h45, inspector #150 verified the door to the laundry chute at the entrance of the West Carleton unit on the second floor and observed that it was not locked.
The laundry chute opening was observed to be large enough to accommodate a large full laundry bag and the laundry chute is not in direct view of the nursing station.

The RPN on the unit was notified by inspector 150 of her observation of the door to the laundry chute. The RPN notified the maintenance manager who came to assess the condition of the door to the laundry chute.

The maintenance manager stated to inspector #150 that the door needed to be replaced because of the poor alignment of the door that did not allow the lock to engage consistently. He stated that a new door will be ordered immediately.
(150)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Immediate

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of June, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROLE BARIL

Service Area Office /
Bureau régional de services : Ottawa Service Area Office