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 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: January 10, 2023	
Inspection Number: 2022-1070-0002	
Inspection Type: Critical Incident System	
Licensee: Carlingview Manor Operating Inc.	
Long Term Care Home and City: Carlingview Manor, Ottawa	
Lead Inspector Sarabjit Kaur (740864)	**Inspector Digital Signature** Sarabjit Kaur Digitally signed by Sarabjit Kaur Date: 2023.01.26 13:22:55 -05'00'
Additional Inspector(s) Erica McFadyen (740804)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 19, 2022 to December 22, 2022

The following intake(s) were inspected:

- Intake: #00004647-[CI: 2420-000043-22] Fall of resident resulting in injury and significant change in status
- Intake: #00005480-[CI: 2420-000046-22] Resident sustained specified injury of unknown cause

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

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with requirement 10 under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the Licensee shall ensure that the hand hygiene program includes access to hand hygiene agents with at least 70-90% alcohol were present on the unit. During an interview with RN #104 on December 21st 2022 it was confirmed that the hand sanitizer wipes contained 62% alcohol.

During an observation of the lunch service on December 20, 2022 it was observed that resident hands were being cleaned prior to the meal using Certainty wipes. Observation of the wipes container did not reveal a list of active ingredients contained within the product. During an interview with ADOC #102 it was stated that the Certainty wipes do not contain at least 70% alcohol.

The impact of this non-compliance is that resident's hand were not cleaned before meals using a hand hygiene agent containing at least 70% alcohol. This increases the risk of disease transmission among residents.

Sources:
Observations, interviews with RN #104, ADOC #101, and IPAC Lead #105

[740804]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital

and which results in a significant change in the resident's health condition.

Rationale and Summary
Resident #002 sustained a fall and was sent to the hospital for assessment. Progress notes reviewed for resident #002 indicate that the licensee was informed on a specified date that resident #002 had sustained an injury. Review of CIS 2420-000043-22 shows that the home first reported this incident to the Director five days after the incident occurred. During an interview with Acting DOC #101 it was stated that the home failed to notify the director within one business day after the occurrence of an incident which caused injury to a resident for which the resident is taken to hospital and which resulted in a significant change in the resident's health condition.

There was no impact to the resident as a result of this non-compliance. The risk of this non-compliance is that the Director was not promptly informed of an incident within the home.

Sources:
Interview with Acting DOC #101, CIS 2420-000043-22, progress notes for resident #002

[740804]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 139 1.

The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times, when not in use.
During an observation on December 19, 2022 the medication room door on the specified floor was left open with no registered staff present. There was a resident present in front of the open medication room during the observation. ADOC #102 arrived after eight minutes of the inspector's observation and confirmed that they forgot to lock the door when they went to attend to a resident.
The impact of the non-compliance is that residents can get access to the medications. This puts the residents at a moderate risk.

Sources
Observations of the medication room
Interview with the ADOC#102
[740864]

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