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
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Original Public Report

Report Issue Date: January 30, 2023

Inspection Number: 2023-1070-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Carlingview Manor Operating Inc.

Long Term Care Home and City: Carlingview Manor, Ottawa

Lead Inspector	**Inspector Digital Signature**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.02.24 09:15:43 -05'00'

Additional Inspector(s)
Laurie Marshall (742466)
Megan MacPhail (551)
Marko Punzalan (742406)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 11-13, 16, 18, 2023

The following intake(s) were inspected:

- Intake: #00003854-[AH: IL-03904-AH/CI: 2420-000041-22] Resident and co-resident alleged sexual abuse
- Intake: #00006722-[AH: IL-99687-AH/CI: 2420-000007-22] - Improper care of resident.
- Intake: #00007130-[IL: IL-05240-OT] Complainant has concerns with residents care.
- Intake: #00008614-2420-000050-22 Fall of resident resulting in injury.
- Intake: #00014767-2420-000060-22: Injury to resident of unknown cause.
- Intake: #00015890-2420-000066-22 Complaint from family with allegations of neglect of a resident
- Intake: #00016268-IL-08422-OT Complainant regarding resident concerns with personal care, nutrition and hydration and plan of care.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary:

A resident was assessed as requiring two-staff physical assistance for transfers. The same resident was transferred by one personal support worker from their bed to chair.

After supper, the resident reported pain, and swelling was discovered where the resident was reporting pain. The resident was sent to hospital and diagnosed with an injury.

The PSW who transferred stated that that the resident required two-staff assistance for transfers, and they transferred the resident without a second person. The Assistant Executive Director stated that the resident's assessed need was two-staff for transfers, however the home's investigation concluded that the transfer was unlikely to have caused the fracture.

The Safe Resident Handling policy and procedure stated that staff will complete transfers and lifts according to the resident's plan of care.

Sources: The resident's health care record, interviews with the PSW and the Assistant Executive Director, Safe

Resident Handling policy and procedure (dated March 31, 2021).

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2. The licensee has failed to ensure that two personal support workers (PSW) used transferring and positioning devices safely when assisting a resident.

Rationale and summary:

A resident was left unattended on the toilet for an extended period of time, attached to a transfer and positioning device.

According to the incident report completed by the Registered Nurse (RN) on duty, the resident was found on the toilet attached to the transfer and positioning device at the start of the evening shift. The resident was immediately provided care and returned to bed when discovered.

In their interviews, both PSWs stated that they assisted the resident onto the toilet and unintentionally left the resident there, unattended, for the rest of their shift. Both PSWs stated in their interviews that the resident should not have been left unattended while attached to the transfer and positioning device.

According to the interview with the Executive Director (ED), the PSWs left resident on the toilet until the evening shift discovered the resident. According to the interview notes from the investigation conducted by the ED with one of the PSWs, both PSWs left the resident on the toilet hours and the resident remained on the toilet, attached to the transfer, and positioning device, until the resident was discovered by the evening staff about one hour and forty-five minutes later. In the interview notes, the also ED states that the policy sates that residents are not to be left unattended on any transfer and positioning device.

According to the Safe Resident Handling policy and procedure (dated March 31, 2021), two staff must be present while the transfer and positioning device is in operation.

Sources:
The resident healthcare record.
The resident's incident report.
Safe Resident Handling policy (dated March 31, 2022)
Interviews with the responsible PSWs, Interview with ED.
Interview notes conducted by the ED with one of the responsible PSWs.

[740785]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

A person, who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, failed to immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:

The resident involved was assessed as requiring two-staff physical assistance for transfers.

A PSW, on their own, transferred the resident from their bed to chair.

After supper, the resident reported pain, and swelling was discovered at the sight where the pain was reported. The resident was sent to hospital and diagnosed with an injury.

The Director was notified when Critical Incident 2420-000060-22 was submitted, which was at a date later than the occurrence of the injury.

The Assistant Executive Director stated that the Director should have notified immediately as the improper transfer resulted in a risk of harm to the resident.

Sources: Interview with the Assistant Executive Director, CIR 2420-000060-22.

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