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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

**Report Issue Date:** December 19, 2023

**Inspection Number:** 2023-1070-0007

**Inspection Type:**
Complaint
Critical Incident
Follow up

**Licensee:** Carlingview Manor Operating Inc.

**Long Term Care Home and City:** Carlingview Manor, Ottawa

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Dee Colborne (000721) | Diana (Dee) Colborne<br>Digitally signed by Diana (Dee) Colborne<br>Date: 2023.12.27 11:07:43 -05'00' |

**Additional Inspector(s)**
Saba Wardak (000732)

# INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 6, 7, 8, 11, 12, 15, 2023

The following intake(s) were inspected:

- Intake: #00098631 - Resident to resident alleged physical abuse resulting in injury.
- Intake: #00099899 -Resident to resident alleged physical abuse resulting in injury.
- Intake: #00100300 - Follow-up #: 1 - O. Reg. 246/22 - s. 40- related to transfers and positioning.
- Intake: #00100416 - Incident resulting in a significant change in condition.

- Intake: #00100857 - Unwitnessed fall resulting in a significant change in condition.
- Intake: #00101660 - Resident to resident alleged sexual abuse.
- Intake: #00101805 -Complaint in regards to alleged sexual abuse.
- Intake: #00103062 - Resident to resident alleged sexual abuse.

The following intake(s) were completed in this inspection:

- Intake: #0097371, intake: #00098309, were all related to falls.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1070-0006 related to O. Reg. 246/22, s. 40 inspected by Dee Colborne (000721)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 6 (2)**

Plan of care

Based on assessment of resident

s. 6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident. Specifically, the licensee has failed to ensure that a bariatric bed was provided for a resident as per their needs.

**Rationale and Summary:**

A resident of the home has a specific body condition. On a specified date in December 2023, a resident was observed in their bed in a supine position on a couple of occasions. The head of the bed was at different heights and pillows were noted under the resident's knees and heals for positioning. During observations on specified dates, it was noted that the resident was unable to be repositioned on one side due to the type of bed. The resident has limited bed mobility and requires total assistance to reposition in bed.

Resident's written care plan states and the Occupational Therapist (OT) confirmed that the resident must be repositioned every two hours when in bed. PSW's also confirmed that the direct care staff are unable to reposition the resident completely on to one side because the bed is not specific to their needs. As such, direct care

staff are utilizing alternative repositioning methods to relieve pressure off of resident and to prevent skin breakdown.

Failure to ensure that the resident's bed needs were assessed can result in harm to the resident.

Sources: Resident's written care plan, observations of resident, and interviews with staff.

[000732]

## WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
Duty of licensee to comply with plan
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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

**Rationale and Summary:**

The written plan of care indicated that a resident was on constant one to one observation.

A personal support assistant (PSA),confirmed that they were assigned one to one with the resident on a specified date in October 2023, and were not with the

resident when the resident attempted to harm another resident.
The Assistant Director of Care (ADOC) confirmed that the PSA left a few minutes early and they are supposed to wait until they are relieved by the next staff coming on shift.

Failure to ensure that the plan of care was followed regarding one to one with a resident resulted in physical harm to a co-resident.

**Sources:** Plan of care, interviews with ADOC , PSA, and other staff.
[000721]

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