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: March 11, 2024

Inspection Number: 2024-1070-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Carlingview Manor Operating Inc.

Long Term Care Home and City: Carlingview Manor, Ottawa

Lead Inspector	**Inspector Digital Signature**
Mark McGill (733)	Mark J McGill Digitally signed by Mark J McGill Date: 2024.03.19 09:04:37 -04'00'

Additional Inspector(s)
Karen Buness (720483)
Severn Brown (740785)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 8, 9, 12, 13, 14, 15, 2024

The following intake(s) were inspected:
- Intake: #00095975 - Related to a disease outbreak
- Intake: #00105640 - Related to a disease outbreak
- Intake: #00021317 - Related to an unexpected resident death
- Intake: #00098630 - Related to alleged resident to resident sexual abuse.
- Intake: #00105337 - Related to alleged staff to resident abuse
- Intake: #00104910 - Related to a missing resident for more than 3 hours

· Intake: #00105872 - Complaint related to resident safety and provision of care

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

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure the plan of care provided clear directions to staff and others who provide direct care to a resident.

On a specific date, Inspector observed a resident lying in bed asleep. A personal Support Worker (PSW) was sitting in a chair at the resident's bedside. When

interviewed the PSW stated they were covering for the PSW, who was assigned to provide 1:1 constant observation to the resident during the day shift, while they were on break. The PSW reported they were directed to stay with the resident at all times. When asked why the resident requires constant observation they stated they did not know. When interviewed, the PSW assigned as the day shift 1:1 reported the resident requires 1:1 constant observation because the resident can sometimes become agitated due to wanting to go outside to smoke.

When interviewed, the Director of Care (DOC) stated the resident requires 1:1 constant observation due to suicidal ideations.

During an interview with the evening Registered Practical Nurse (RPN), they stated the resident has been assigned 1:1 constant observation due to voicing suicidal ideations, specifically jumping out of the window. Inspector interviewed the PSW assigned as the evening shift 1:1 for the resident. The PSW reported the resident requires 1:1 constant observation because they always wanted to go home.

A review of the resident's written plan of care revealed the resident's history of suicidal ideations was not included in the written plan of care. Interventions related to the risk of elopement included increased monitoring for identified exit seeking in the evening, safety checks every hour and temporary transfer to the locked unit with 1:1 constant observation, which started on December 23, 2023. The care plan indicated the need for 1:1 constant observation would be reassessed in two weeks. A review of the resident's health record revealed it had not been reassessed.

Inspector observed a 1:1 monitoring information sheet posted on the communication board in the medication room. The information sheet indicated the resident required 1:1 constant monitoring due to exit seeking and risk of elopement.

Failure to ensure the plan of care provided clear direction to the staff put the resident at an increased safety risk.

Sources: Resident health record, staff communication board, interviews with the Director of Care, registered staff and personal support workers.

[720483]

COMPLIANCE ORDER CO #001 Doors in a home

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A. Provide direction to all staff regarding the instructions related to exiting the front entrance.
B. Perform daily audits at various times of the day/shifts to ensure that staff are following the exiting instructions. Audits are to be conducted until compliance is demonstrated.
C. Take corrective actions to address staff non-compliance related to exiting the

front entrance.
D. Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure all doors leading outside the home were closed and locked.

On a specific date and time, a resident exited the home unattended through the front entrance. The resident was located by the police hours later at a location, approximately 1.3 kilometers away from the home. The resident was not dressed appropriately for the weather. Once returned to the home the resident was sent to hospital for assessment due to being outside in the cold for an extended period of time.

Upon reviewing the camera footage, the licensee determined a staff member left the home and did not wait to ensure the first door, which exits into a vestibule, was closed prior to exiting the main door.

Inspector observed the front entrance, it was noted that the first door which exits into the vestibule requires a passcode. It was further noted that once the passcode was entered the first door opened automatically and stayed open for 20 seconds.

In an interview with the DOC, they reported all staff received training which instructs staff to wait in the vestibule to ensure the first door has closed and no residents have followed them out the door prior to exiting.

Failure to ensure the front entrance was secure and locked put the resident at high risk for injury when they were able to leave the building the night of the incident.

[720483]
This order must be complied with by April 22, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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