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
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 21, 2023	
Inspection Number: 2023-1184-0003	
Inspection Type: Complaint	
Licensee: Carveth Nursing Home Limited	
Long Term Care Home and City: Carveth Care Centre, Gananoque	
Lead Inspector Anna Earle (740789)	**Inspector Digital Signature** Anna M Earle Digitally signed by Anna M Earle Date: 2023.06.27 08:24:06 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 14 - 15, 2023

The following intake(s) were inspected:

- Intake: #00089244 - Complaint regarding twice weekly bathing of residents.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

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

Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary
Residents #002 and #003 were scheduled to receive a bath. Point of Care (POC) bathing documentation showed that the PSW staff documented "not applicable" (meaning it was not completed) for the resident's scheduled baths. In interviews with PSW #102 and #103, it was stated that the residents do not always receive their scheduled baths.

Resident #001 was scheduled to receive a bath. POC bathing documentation showed that the PSW staff documented "not applicable" (meaning it was not completed) for the resident's scheduled baths. In an interview with PSW #102, 103, and RPN #104, it was stated that the residents do not always receive their scheduled baths.
In an interview with Assistant Director of Care #100, it was confirmed that baths were not completed on specified dates for residents #001, #002 and #003.

The risk to the residents not receiving baths as scheduled can result in poor hygiene and skin breakdown.

Sources: Clinical documentation review of residents #001, #002, and #003, interviews with PSW #102, #103, RPN #104 and with Assistant Director of Care #100.

[740789]

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