

**Ministry of Health
and Long-Term Care**

Health System Accountability and
Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
Facsimile: 613-569-9670

**Ministère de la Santé
et des Soins de longue durée**

Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance
et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4^{ième} étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
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November 17, 2010

Mr. Lawrence Grant
Administrator
Glebe Centre
950 Bank Street
Ottawa ON K1S 5G6

Dear Mr. Grant:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on September 3, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

A handwritten signature in black ink that reads "Lyne Duchesne".

Lyne Duchesne
LTC Home Inspector – Nurse

c President, Resident's Council
President, Family Council



**Inspection Report
under the *Long-Term
Care Homes Act, 2007***

**Rapport d'inspection
prévus le *Loi de 2007
les foyers de soins de
longue durée***

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Licensee Copy/Copie du Titulaire



Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection September 3, 2010	Inspection No/ d'inspection 2010_188_2811_03Sept095639	Type of Inspection/Genre d'inspection Complaint Log # O-000391
Licensee/Titulaire The Glebe Centre 950 Bank St Ottawa ON K1S 5G6 Fax: (613) 238-4759		
Long-Term Care Home/Foyer de soins de longue durée The Glebe Centre Incorporated 950 Bank St Ottawa ON K1S 5G6 Fax: (613) 238-4759		
Name of Inspector(s)/Nom de l'inspecteur(s) Lyne Duchesne #117		
Inspection Summary/Sommaire d'inspection		

The purpose of this inspection was to conduct a complaint inspection related to the care and services provided to an identified resident.

During the course of the inspection, the inspector spoke the home's administrator; the home's director of care; the home's assistance director of care; a Registered Nurse working on September 3, 2010; to two health care aids working on September 3 2010 and to the identified resident.

During the course of the inspection, the inspector reviewed the identified resident's health care records, reviewed the resident care unit equipment cleaning schedules, reviewed the resident care unit's night time health care aid work routine directives, observed the provision of morning care to the identified resident on the resident's care unit, observed the lunch time meal service of September 3 2010 on the resident's care unit, examined the identified resident's room and observed the identified resident's early afternoon care on September 3, 2010.

The following Inspection Protocols were during this inspection:

- Falls Prevention
- Personal Support Services
- Skin and Wound
- Ad Hoc Notes

3 Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c.8, 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 direction to staff and others who provide direct care to the resident.

(9) The licensee shall ensure that the following are documented:

1. the provision of the care set out in the plan of care.
2. the outcomes of the care set out in the plan of care.
3. the effectiveness of the plan of care.

(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- b) the resident's care needs change or care set out in the plan is no longer necessary; or
- c) care set out in the plan has not been effective.

Findings:

1. The resident's care plan indicates that the resident has a wheelchair lap belt restraint that is to be applied when the resident is up in the wheelchair, is to be removed and the resident is to be readjusted / repositioned every 1 hour. Health care aid daily care directives do not identify the need to apply, remove and readjust / reposition the resident every 1 hour.
2. The resident's plan of care indicates that staff are to provide constant supervision and physical assistance for safety during toileting. The attending health care aid did not stay with the resident when she was seated on the toilet on February 25 2010. The resident fell and sustained an injury.
3. The resident's wheelchair lap belt, seat cushion and arm rest sides were soiled with food debris and liquid spillage on September 3, 2010. The resident's plan of care does not identify the need to regularly clean the resident's wheelchair.

Inspector ID #: # 117

WN #2: The Licensee has failed to comply with the O.Reg. 79/10, section 110 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

- (5) the person who applied the device and the time of application.
- (6) all assessment, reassessment and monitoring, including the resident's response.
- (7) every release of the device and all repositioning
- (8) The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Findings:

1. There is no documentation that the resident's lap belt was applied, removed and readjusted / repositioned as well as the resident's response every 1 hour, as per the resident's plan of care, from November 2009 to September 2010.

Inspector ID #: # 117

WN #3: The Licensee has failed to comply with the O.Reg. 79/10, Section 37(1)(b) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
b) cleaned as required.

Findings:

1. The resident's wheelchair lap belt, seat cushion and arm rest sides were soiled with food debris and liquid spillage on September 3, 2010.

Inspector ID #: # 117

**Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné**

**Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.**

Title:

Date:

Date of Report: (if different from date(s) of inspection).

October 13, 2010

