Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 16, 2015	2015_295556_0017	O-002139-15, O-002138-15, O-001742-15, O-001741-15	Critical Incident System

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET OTTAWA ON K1S 5G6

Long-Term Care Home/Foyer de soins de longue durée

GLEBE CENTRE
950 BANK STREET OTTAWA ON K1S 5G6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 26, 29, 30, and July 2, 3, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Manager of Resident Care Operations (MRCO), Registered Nurses (RN), Registered Practical Nurses (RPN), Coordinator of Nursing Programs (CNP), BSO Champion, PSW's, and Housekeeper.
While in the home the inspector reviewed resident health care records, internal incident reports/documentation, observed staff to resident, and resident to resident interactions, reviewed policy and procedure RC 08.03.02 Resident Abuse and Neglect, and the procedure for Investigation and Reporting.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of an incident that caused an injury to Resident #003, and Resident #006, that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

During the course of an inspection two critical incident reports were reviewed.

One critical incident report indicated that Resident #003 experienced a fall on a specific date however the Critical Incident Report was not submitted to the MOHLTC until eleven days later.

Resident #003's health care record indicated that on a specific date the resident suffered an unwitnessed fall and was found lying face down on the floor. Upon assessment the resident was noted to have specific injuries to the head and face. Resident #003 was transferred to hospital for assessment and returned to the home the same day. A progress note dated the day after the incident indicated that the resident had a specific head injury.

In an interview RN #100 and PSW #101 both stated that the fall with resulting injury very definitely resulted in a change in Resident #003's health condition. PSW #101 stated that before the fall Resident #003 could ambulate independently on the unit and only required the assistance of one staff to transfer, however afterward the resident could no longer ambulate independently, and required two people to transfer.

In an interview the Manager of Nursing Care Operations indicated that when an incident occurs the registered staff on the unit complete an incident report and submit it the same day either to herself or to the DOC who review them no later than the following business day. She further stated that she was aware of the incident involving Resident #003's at the time that it occurred but thought she had 10 business days to report the incident to the MOHLTC. [s. 107. (3) 4.]

2. The second critical incident report indicated that Resident #006 experienced a fall on a specific date however the Critical Incident Report was not submitted to the MOHLTC until eight days later.

Resident #006's health care record indicated that on a specific date the resident suffered an unwitnessed fall and afterward was unable to straighten his/her limb due to extreme pain. Resident #006 was transferred to hospital and a progress note dated one day after

the incident indicated that the resident had a specified fracture.

In an interview RPN #105 stated that Resident #006's condition changed significantly after the specified fracture. RPN #105 stated that before the fracture the resident was ambulating independently with a walker, and could transfer and toilet him/herself, but after the fracture Resident #006 became dependent on staff for mobility, toileting, and transferring.

In an interview the DOC stated that the Manager of Nursing Care Operations did not submit the CIR within one business day of the occurrence of the incident because the home thought that they had 10 business days to report such incidents to the MOHLTC. [s. 107. (3) 4.]

Issued on this 17th day of July, 2015

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.