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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 9, 2016	2016_384161_0021	004654-16	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

KATHLEEN SMID (161)

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 7, 2016.

During the course of the inspection, the inspector(s) reviewed a Critical Incident related to the fall of resident #001 and the resident's health care record.

During the course of the inspection, the inspector(s) spoke with the identified resident and the Manager of Nursing Care Operations.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed no less than one business day of an incident that caused an injury to resident #001 that resulted in a significant change in the resident's health condition and for which resident #001 was taken to hospital.

On an identified date in January 2016 the Director was notified via the Critical Incident Report System that on an identified date in January 2016 resident #001 was witnessed by a PSW to self-transfer from a wheelchair to a bed; and in doing so, the resident fell to the floor and landed on his/her knees. The resident was immediately assessed by a registered staff member and no obvious injuries were apparent. Over the course of the following two days resident #001 experienced increased pain in his/her right knee, difficulty mobilizing and refused to be transferred to the hospital.

Two days later, on an identified date in January 2016, resident #001 agreed to be transferred to the hospital where he/she was diagnosed with a fractured right knee. The resident underwent surgical intervention and was transferred back to the home two days later.

On June 7, 2016 Inspector #161 discussed the information contained in the Critical Incident Report (CIR) with the Manger of Nursing Care Operations who had initiated the CIR and submitted it to the Director on an identified date in January 2016. The CIR submission was 6 days after resident #001 had been admitted to the hospital. When questioned by Inspector #161 as to why she did not immediately report the information to the Director, the Manager of Nursing Care Operations indicated to Inspector #161 that the registered staff member did not inform her of resident #001's fall and transfer to a hospital until 6 days after resident #001 had been admitted to hospital. She indicated that registered staff would be re-educated on the reporting requirements of critical incidents to the Director. [s. 107. (3)]

Issued on this 9th day of June, 2016

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

Original report signed by the inspector.