Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2020	2020_617148_0001	020413-19	Complaint

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 8, 9 and 10, 2019

This inspection included one complaint related to the resident's right to receive visitors of his or her choice.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Manager of Nursing Operations, Director of Care, Registered Nursing Staff, Social Worker, Personal Support Workers, resident and family member.

In addition, the Inspector reviewed the resident's health care record, correspondence and a Trespass to Property Notice. The Inspector also observed the resident and the resident's care environment.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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	Légende 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the right of resident #001 to receive visits from family member #100 was fully respected and promoted.

Resident #001 was admitted to the home on a specified day. Resident #001 has impaired cognition and was not able to participate in a discussion, with the Inspector, related to the resident's choice to receive visitors.

Family member #100 attended the home on the date of admission and for the following next two days, to visit with resident #001. Family member #100 accompanied the resident to leave the building for an outing on two of those days.

On the afternoon of the third day, family member #100 was approached by RPN #103 to discuss visitation times with resident #001. The purpose of this discussion, as described by the RPN, was to ensure that family member #100 and SDM #101 could continue their visits with the resident. In addition, the RPN wished to discuss off unit activities and outings as it related to the resident's ability to settle into the resident's new environment. As indicated by interviews with staff members including RPN #103, PSW #106 and the Executive Director, along with documentation maintained by the ED and the health care record, family member #100 reacted verbally and physically to RPN #103 when approached. Due to the escalation of the situation, the police force was called by RPN #103 and family member #100. The police force arrived and escorted family member #100 out of the building.

On the following day, the ED issued a Trespass to Property Notice to family member #100, which indicated that family member #100 was prohibited from visiting the property and premises of the home. As reported by the ED, and as documented in a letter written to family member #100 dated three weeks later, the Trespass to Property Notice was issued due to the events involving RPN #103. At the time of the issuance of the notice, the ED indicated that there was no contact information for family member #100. However, within days of the issuance, the ED received a phone call from family member #100. During this call, the ED reported the reasons for the Trespass to Property Notice and offered to meet with the family member to discuss conduct in the home and resuming visitation with resident #001, whereby the Trespass to Property Notice could be lifted. Family member #100 refused to meet with the ED.

Over the next five weeks, family member #100 attended the home on two occasions. As

indicated by the family member, the intention of coming to the home, in part, was to visit with resident #001. On both occasions, the family member was informed of the Trespass to Property Notice and asked to leave the home. On both occasions, the police force was called and family member #100 was escorted out of the building.

Approximately seven weeks after the issuance of the Trepass to Property Notice, the ED emailed family member #100 to which a letter, was attached. The letter describes a phone call, that took place two weeks prior, between the ED and family member #100, whereby the ED offered to meet to discuss the rules to which all visitors are to follow. The letter indicated that family member #100 reported no intention to meet with the ED or any other staff member on this matter. The letter noted the ED's intent to reach out again at this time, to ask the family member to reconsider meeting with the ED to discuss conditions that would allow for family member #100 to resume visits with resident #001.

Although efforts have been made to meet with family member #100 to discuss the re-establishment of visits with resident #001, the issuance of a Trespass to Property Notice did not fully respect and promote resident #001's right to receive visitors. Specifically, this right was not respected and promoted on two occasions, when resident #001 was denied a visit from family member #100.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.