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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 22, 2020	2020_617148_0006	000889-20, 001287-20	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): March 4, 5 and 6, 2020

This inspection included two complaint intakes: Log 001287-20 concerning the resident's right to receive visitors and Log 000889-20 concerning the continence care of an identified resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Manager of Nursing Operations, Director of Environmental Services, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a family member and an identified resident.

The Inspector reviewed the health care record of the identified resident and documents related to visitation. In addition, the Inspector observed the resident's care environment and resident care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 has identified diagnoses and was not able to participate in a discussion related to the resident's choice to receive visitors.

Family member #100 attended the home on a specified date, to visit with resident #001. Upon arrival to resident #001's unit, family member #100 was denied entry. The family member was then approached by the Director of Environmental Services who informed the family member of restrictions to visitations in place. The Director of Environmental Services requested that the family member leave the property to which family member #100 refused. The Director of Environmental Services than contacted the local police force; the police force escorted family member #100 out of the building.

The licensee did not fully respect and promote resident #001's right to receive visitors on a specified date, when resident #001 was denied a visit from family member #100.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident has the right to receive visitors of his or her choice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that resident #001, who required continence care products, had sufficient changes to remain clean, dry and comfortable.

Resident #001 was described by the plan of care to be incontinent of urine and required the use of continence care products. The most recent MDS Assessment and plan of care described the resident as dependent on staff for toileting and continence care.

On a specified date, a family member of resident #001 observed the resident to be in bed and described the resident to be soaked in urine. A progress note written on the same date, by RPN #107, indicated that resident #001 had refused to get up out of bed during morning care and was found heavily incontinent of urine.

Inspector #148 spoke with RPN #107 who described that on the morning of the incident, resident #001 did not want to be risen from bed. The RPN described that several attempts were made between 0700 and 0930 hours to rise the resident. The RPN recalls PSW #109 reporting that the resident did not want to rise, however, the RPN could not confirm if the resident's continence status was observed between 0700 and 0900 hours. At approximately 1000 hours, the family member arrived on the unit and both RPN #107, PSW #109 and the family member approached the resident in bed and observed that the soaker pad on the bed was saturated in urine. PSW #109 does not recall the incident and could not speak to when the resident was last observed, prior to 1000 hours.

Resident #001 was not provided with sufficient changes to remain clean and dry on a specified date.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #001, who requires continence care products has sufficient changes to remain clean, dry and comfortable., to be implemented voluntarily.

Issued on this 26th day of May, 2020

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

Original report signed by the inspector.