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
Jul 22, 2020	2020_559142_0005	008069-20	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

JANET MCPARLAND (142)

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): June 23, 24, 25, 26, 29, July 2 and 6, 2020 (offsite inspection)

Complaint Log #008069-20 related to resident care was inspected.

During the course of the inspection, the inspector(s) spoke with a resident's substitute decision-maker (SDM)/ Power of Attorney (POA), Registered Practical Nurses (RPN), Registered Nurse (RN) and the Director of Care (DOC).
During the course of the inspection, this inspector reviewed the resident's health care record and email correspondence.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's substitute decision-maker (SDM) was provided the opportunity to participate fully in the development and implementation of the resident's plan of care when the resident experienced a change in condition.

In a review of resident #001's health record, it was noted in the progress notes that on an identified date and time, resident had a change in their health condition. Resident's physician was notified and they advised the registered staff member to contact resident's Power of Attorney (POA) and they further indicated that if the POA wanted the resident sent to hospital then send resident to hospital. It was indicated in the progress notes that a telephone call was placed to the POA and a message was left. The registered staff member further documented that they were waiting for a call from the POA to determine further interventions.
A progress note entry on an identified date and time, indicated that there had not been a call back from the POA.

On an identified date an entry in the progress notes indicated that the resident had a change in health condition.

On an identified date, the resident's physician notified the POA of the resident's change in health condition.

In a review of resident's health care record, it was noted that their advanced directives indicated a specific level of care.

Upon further review of the progress notes during an identified period of time, there was no documentation indicating that staff spoke to the resident's POA regarding the resident's change in health condition which occurred on identified dates.

In email communications on specified dates to the DOC, the resident's POA expressed their concern that they were not notified of the resident's change in health condition until the resident's physician notified them on an identified date. The POA indicated that if resident had another change in health condition they requested that the resident be sent to hospital for further evaluation. The POA further indicated that would have been their direction if they had been notified in a prompt manner following the resident's change in condition on the identified dates.

In an interview with the resident's POA, they indicated to Inspector #142 that they were

not notified of the resident's change in health condition until a discussion with the physician on an identified date. They indicated that they had contacted the home after the message was left on an identified date and left a voicemail message for the nurse. They contacted the home again the following day, as their call was not returned, and when they spoke to the nurse, the nurse was unable to determine the reason why a voicemail message was left for the POA on the identified date.

During interviews with registered staff members # 101, 102, and 103, they all indicated that they do not recall speaking with the resident's POA regarding the resident's change in health condition on the identified dates. They further indicated that it is the expectation that they continue to contact a POA until they speak to a resident's POA when a resident experiences a change in condition.

In an interview with the Director of Care, they confirmed, that it is the expectation that registered staff make every effort to speak to a resident's POA when a resident experiences a change in condition.

The licensee failed to ensure that the resident's SDM (POA) was provided the opportunity to participate fully in the development and implementation of the plan of care following resident's change in condition. [s. 6. (5)]

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 the resident, resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.