

**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

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 18, 2021	2021_617148_0005	000874-21	Critical Incident System

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**Licensee/Titulaire de permis**

The Glebe Centre Incorporated  
950 Bank Street Ottawa ON K1S 5G6

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

Glebe Centre  
950 Bank Street Ottawa ON K1S 5G6

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

AMANDA NIXON (148)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): January 29 and Feb 2-4 and 10, 2021, as an off site inspection**

**The following intake was completed during this critical incident inspection: Log 000874-21 related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in health status.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Coordinator of Nursing Programs, Director of Quality Management, a Registered Nurse (RN), a Registered Practical Nurse (RPN) and Personal Support Workers (PSW).**

**In addition, the inspector reviewed resident health care records**

**The following Inspection Protocols were used during this inspection:  
Minimizing of Restraining  
Personal Support Services  
Safe and Secure Home**

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

**4 WN(s)**

**2 VPC(s)**

**2 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

Specifically failed to comply with the following:

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**

**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**

**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**

**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that three residents, who had bed rails in use, had a resident assessment and bed system evaluation in accordance with prevailing practices.

Three residents had bed rails in use. It was determined that the three residents did not have a resident assessment or bed system evaluation in accordance with evidence-based practices. The licensee had not implemented a program to conduct resident assessments or bed system evaluations for those residents with bed rails in use.

Source: The plans of care for three residents and interviews with Coordinator of Nursing Programs, Executive Director and other staff. [s. 15. (1) (a)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

Specifically failed to comply with the following:

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**

**7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care for three residents, was based on an interdisciplinary assessment of the physical functioning and the type and level of assistance that was required related to activities of daily living.

The most recent interdisciplinary assessment indicated that a resident required two person assist for activities of daily living including toileting, pericare and bed mobility. This was confirmed by staff familiar with the resident's care.

The resident's plan of care did not include the need for two person assist with care such as toileting, pericare or bed mobility. This resident was provided care by one PSW, during this care the resident sustained an injury.

In addition, the plan of care for two other residents did not include the type and level of assistance that was required for activities of daily living, such as toileting and hygiene.

Sources: Minimum Data Set assessments and plans of care for three residents and interviews with a PSW, Coordinator of Nursing Programs and other staff. [s. 26. (3) 7.]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31.  
Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that three residents were restrained by a physical device only when the restraining of the resident was included in the resident's plan of care.

Three residents had in use two long bed rails when in bed, to which the residents could not remove. The bed rails were described by staff to be used for safety, to ensure the residents did not fall out of bed. The bed rails used as restraints were not included in the plans of care.

Source: The plan of care for three residents and interviews with Coordinator of Nursing Programs and other staff. [s. 31. (1)]

***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 a resident is restrained by a physical device only when the restraining of the resident has been included in the plan of care, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

A PSW was present when a resident fell from the resident's bed to the floor. The PSW then transferred the resident from the floor to the bed, prior to the resident having a clinical assessment.

The transfer of the resident did not use safe techniques, in that the resident had sustained a fall and additionally the resident required a two staff for transfers.

Sources: Review of a resident progress notes and plan of care and interview with a PSW and other staff. [s. 36.]

***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 safe transferring techniques are used when assisting residents, to be implemented voluntarily.***

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Issued on this 24th day of February, 2021

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** AMANDA NIXON (148)

**Inspection No. /**

**No de l'inspection :** 2021\_617148\_0005

**Log No. /**

**No de registre :** 000874-21

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Feb 18, 2021

**Licensee /**

**Titulaire de permis :** The Glebe Centre Incorporated  
950 Bank Street, Ottawa, ON, K1S-5G6

**LTC Home /**

**Foyer de SLD :** Glebe Centre  
950 Bank Street, Ottawa, ON, K1S-5G6

**Name of Administrator /**

**Nom de l'administratrice  
ou de l'administrateur :** Lawrence Grant

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To The Glebe Centre Incorporated, you are hereby required to comply with the following order(s) by the date(s) set out below:



**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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**Order # /****No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

**Order / Ordre :**

The licensee must be compliant with O. Regulation 79/10, s.15(1).

Specifically the licensee must:

Ensure that all residents with bed rails in use are assessed and their bed system evaluated in accordance with prevailing practices.

**Grounds / Motifs :**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

1. The licensee has failed to ensure that three residents, who had bed rails in use, had a resident assessment and bed system evaluation in accordance with prevailing practices.

Three residents had bed rails in use. It was determined that the three residents did not have a resident assessment or bed system evaluation in accordance with evidence-based practices. The licensee had not implemented a program to conduct resident assessments or bed system evaluations for those residents with bed rails in use.

Source: The plans of care for three residents and interviews with Coordinator of Nursing Programs, Executive Director and other staff

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm as residents with bed rails in use have not been provided with a resident assessment or bed evaluation in accordance with prevailing practices. Scope: The scope of this non-compliance was identified as widespread as it was identified that no resident with bed rails in use has been provided with a resident assessment or bed evaluation in accordance with prevailing practices. Compliance History: There has been no previous non-compliance to O. Regulation 79/10, s.15(1) in the past 36 months.

(148)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

May 18, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Order # /**

**No d'ordre :** 002

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**Order / Ordre :**

The licensee must be compliant with O. Regulation 79/10, s.26(3).

Specifically the licensee must:

Ensure that the plan of care for two residents are reviewed and revised to include the type and level of assistance that is required related to activities of daily living.

At minimum, the plans of care must include the type and level of assistance for: bed mobility, toileting and hygiene.

**Grounds / Motifs :**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

1. The licensee has failed to ensure that the plan of care for three residents, was based on an interdisciplinary assessment of the physical functioning and the type and level of assistance that was required related to activities of daily living.

The most recent interdisciplinary assessment indicated that a resident required two person assist for activities of daily living including toileting, pericare and bed mobility. This was confirmed by staff familiar with the resident's care.

The resident's plan of care did not include the need for two person assist with care such as toileting, pericare or bed mobility. This resident was provided care by one PSW, during this care the resident sustained an injury.

In addition, the plan of care for two other residents did not include the type and level of assistance that was required for activities of daily living, such as toileting and hygiene.

Sources: Minimum Data Set assessments and plans of care for three residents and interviews with a PSW, Coordinator of Nursing Programs and other staff.

An order was made by taking the following factors into account:

Severity: There was actual harm as a resident sustained an injury during the provision of care whereby a staff person provided care alone. Scope: The scope of this non-compliance was identified as widespread as three resident care plans reviewed did not include the type and level of assistance that was required.

Compliance History: One written notification (WN) was issued to the home related to the same section of the legislation in the past 36 months.

(148)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

May 18, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603



**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 18th day of February, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** AMANDA NIXON

**Service Area Office /**

**Bureau régional de services :** Ottawa Service Area Office