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

Amended Public Copy/Copie modifiée 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
Mar 01, 2022	2021_617148_0026 (A1)	011927-21, 011928-21	Follow up

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
77 Monk Street Ottawa ON K1S 5A7

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

Amended by AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

During the Director Referral meeting on February 23, 2022, discussion held on the home's request for extension to the CDD. A formal request was received in writing on February 24, 2022 from the Director of Care to extend the CDD to March 11, 2022.

Issued on this 1 st day of March, 2022 (A1)

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

Original report signed by the inspector.

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

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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
Mar 01, 2022	2021_617148_0026 (A1)	011927-21, 011928-21	Follow up

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
77 Monk Street Ottawa ON K1S 5A7

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

Amended by AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 7, 8, 10, 13, 14, 2021

This inspection followed up on two Compliance Orders, CO #001 related to section 15 of Regulation 79/20 pertaining to bed rail use in the home and CO #002 related to section 229 of Regulation 79/20 pertaining to the infection prevention and control program.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Manger of Infection Prevention and Control, Coordinator of Nursing Programs, Director of Environmental Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping aide, Physiotherapist and residents.

The Inspector reviewed resident health care records, documents pertaining to the bed rail program including resident assessments and bed evaluations and documents pertaining to the infection prevention and control program. The resident care and services were observed including resident rooms, bed systems and infection control practices.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home

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

1 WN(s)
0 VPC(s)
1 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #002	2021_583117_0014	148

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 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 residents, who had bed rails in use, had a resident assessment and bed system evaluation in accordance with prevailing practices.

Four residents were observed with bed rails in use. The Coordinator of Nursing Programs identified these rails as bed assists and identified five additional residents with bed assists in use. As described by the DOC, Coordinator of Nursing Programs and the Bed Safety Program policy, the bed assists were not considered to be bed rails. In this way, there was no bed evaluation of the nine bed systems with these types of bed rails in use.

The licensee's Bed Safety Program policy supports that bed assist devices do not require a bed evaluation or resident assessment as per prevailing practices. Such would only be done when consideration is being given to the use of an alternative bed rail.

A resident was observed to have two alternative rails in use as bed rails. A bed evaluation was conducted on the bed system whereby the system failed at zones 1, 2 and 3. The bed rails remained in use without steps taken to prevent resident entrapment in consideration of the failures identified. Two additional residents were also identified with alternative rails in use as bed rails. There was no bed evaluation of these two bed systems and it could not be demonstrated that steps had been taken to prevent resident entrapment.

A resident was observed with bed rails in use. The most recent bed evaluation indicated failures at zone 3 and 4. It could not be demonstrated that steps had been taken to prevent resident entrapment.

Three residents were observed to have bed rails in use. The resident assessment for each resident recommended that bed rails be removed. The assessments note the use of bed rails or assistive devices but failed to recognize the devices as bed rails that pose entrapment risk. The assessments do not explore the known risks for entrapment or the ways in which to mitigate such risks.

Of eight additional resident assessments reviewed, there were examples whereby the persons consulted during the collection of information varied, exampled by only registered nursing staff or managers being involved or where direct care staff including those familiar with sleep patterns were not involved. The decision to use or discontinue the use of bed rails was made by the RN/RPN leading the data

collection, rather than by an interdisciplinary team. The progress note used to represent the risk benefit assessment did not analyze the risks identified by the resident assessment or explore the ways in which the benefits may outweigh the risks. The resident's risk for entrapment was described as it relates to the bed system rather than the resident's risk factors identified in the resident assessment.

Sources: Observations of resident bed systems and sleeping environment, interviews with the DOC, Coordinator of Nursing Programs, Director of Environmental Services and other staff, review of resident assessments, bed system evaluations and policy #RC 4.07.00 titled Bed Safety Program dated December 2, 2021. [s. 15.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 1 st day of March, 2022 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA NIXON (148) - (A1)
Inspection No. / No de l'inspection :	2021_617148_0026 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011927-21, 011928-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 01, 2022(A1)
Licensee / Titulaire de permis :	The Glebe Centre Incorporated 950 Bank Street, Ottawa, ON, K1S-5G6
LTC Home / Foyer de SLD :	Glebe Centre 77 Monk Street, Ottawa, ON, K1S-5A7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lawrence Grant

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

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

Ordre(s) de l'inspecteur

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: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_583117_0014, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. Bed rails

Order / Ordre :

The licensee must comply with s. 15 (1) of O. Reg. 79/10

Specifically, the licensee must:

1) Review and update the bed rail policy to ensure that the policy is in accordance with prevailing practices.

2) Ensure that the resident assessment uses an interdisciplinary team approach whereby:
a) staff who have knowledge of the resident's care needs are involved;
b) the assessment gathers data specific to the resident's care needs related to the use of bed rails and risk of entrapment as required by prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003); and
c) the resident assessment is documented.

3) Following the resident assessment, ensure that the risk benefit assessment uses an interdisciplinary team approach whereby:
a) the team identifies the resident's risk factors for injury or death of use and non-use of bed rails;
b) the team identifies the resident's benefits of use and non-use of bed rails;
c) the team compares the potential for injury or death associated with the use or non-use of bed rails to the benefits of use or non-use of the bed rails;
d) identification of why other care interventions are not appropriate or not

effective;
e) the decision to continue or discontinue the use of bed rails is made by the team;
f) the team implements strategies to mitigate the resident's identified risks; and
g) the risk benefit assessment is documented.

4) Conduct a resident assessment for the three resident's identified and for all other residents with bed rails in use.

5) Conduct bed evaluations of the nine residents identified with bed assists and take immediate corrective action should any bed system not pass entrapment zone testing.

6) Address bed evaluation failures for the four residents identified, by taking immediate corrective action where the bed system does not pass entrapment zone testing.

Grounds / Motifs :

1. Compliance order #001, related to O. Reg. 79/10, s. 15 (1) from inspection 2020_583117_0014 issued on August 3, 2021, with a compliance due date of November 30, 2021 is being re-issued as follows:

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

Four residents were observed with bed rails in use. The Coordinator of Nursing Programs identified these rails as bed assists and identified five additional residents with bed assists in use. As described by the DOC, Coordinator of Nursing Programs and the Bed Safety Program policy, the bed assists were not considered to be bed rails. In this way, there was no bed evaluation of the nine bed systems with these types of bed rails in use.

The licensee's Bed Safety Program policy supports that bed assist devices do not require a bed evaluation or resident assessment as per prevailing practices. Such would only be done when consideration is being given to the use of an alternative

bed rail.

A resident was observed to have two alternative rails in use as bed rails. A bed evaluation was conducted on the bed system whereby the system failed at zones 1, 2 and 3. The bed rails remained in use without steps taken to prevent resident entrapment in consideration of the failures identified. Two additional residents were also identified with alternative rails in use as bed rails. There was no bed evaluation of these two bed systems and it could not be demonstrated that steps had been taken to prevent resident entrapment.

A resident was observed with bed rails in use. The most recent bed evaluation indicated failures at zone 3 and 4. It could not be demonstrated that steps had been taken to prevent resident entrapment.

Three residents were observed to have bed rails in use. The resident assessment for each resident recommended that bed rails be removed. The assessments note the use of bed rails or assistive devices but failed to recognize the devices as bed rails that pose entrapment risk. The assessments do not explore the known risks for entrapment or the ways in which to mitigate such risks.

Of eight additional resident assessments reviewed, there were examples whereby the persons consulted during the collection of information varied, exampled by only registered nursing staff or managers being involved or where direct care staff including those familiar with sleep patterns were not involved. The decision to use or discontinue the use of bed rails was made by the RN/RPN leading the data collection, rather than by an interdisciplinary team. The progress note used to represent the risk benefit assessment did not analyze the risks identified by the resident assessment or explore the ways in which the benefits may outweigh the risks. The resident's risk for entrapment was described as it relates to the bed system rather than the resident's risk factors identified in the resident assessment.

Sources: Observations of resident bed systems and sleeping environment, interviews with the DOC, Coordinator of Nursing Programs, Director of Environmental Services and other staff, review of resident assessments, bed system evaluations and policy #RC 4.07.00 titled Bed Safety Program dated December 2, 2021.

An order was re-issued by taking the following factors into account: 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. The scope of this non-compliance was identified as widespread as it was identified that residents with bed rails in use have not been provided with a resident assessment or bed evaluation in accordance with prevailing practices. Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 15 (1) of O. Reg 79/10. This section was issued as a CO on February 18, 2021 during inspection 2021_617148_0005 with a compliance due date of May 18, 2021 and re-issued as a CO on July 22, 2021, during inspection 2021_583117_0014 with an amended compliance due date of November 30, 2021. As this will be the third CO under this section, a Directors Referral will also be initiated. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2022(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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

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

Ordre(s) de l'inspecteur

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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 revision 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
438, rue University, 8e étage
Toronto ON M7A 1N3
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.

Issued on this 1 st day of March, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AMANDA NIXON (148) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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