Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Ottawa District**
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

**Report Issue Date: May 5, 2023**

**Inspection Number:** 2023-1301-0002

**Inspection Type:**
Complaint
Critical Incident System

**Licensee:** The Glebe Centre Incorporated

**Long Term Care Home and City:** Glebe Centre, Ottawa

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Laurie Marshall (742466) | Laurie R Marshall Digitally signed by Laurie R Marshall Date: 2023.05.05 14:05:56 -04'00' |

**Additional Inspector(s)**
Gurpreet Gill (705004)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14,17-21 and April 24- 28, 2023

The following intake(s) were inspected:

- Intake: #00011522 - IL-06500-OT: Complainant concerns about resident care plan not being followed.
- Intake: #00013172 - 2811-000037-22: Fall of resident resulting insignificant change in condition.
- Intake: #00013703 - 2811-000039-22: Alleged staff to resident neglect.
- Intake: #00013987 - IL-07485-OT: Complaint related to alleged abuse of resident.
- Intake: #00018921 - 2811-000003-23; #00020507 - 2811-000011-23: Fall incident that caused injury to resident and significant change in condition.
- Intake: #00019532 - IL-09736-OT Complaint related to cold temperature.
- Intake: #00020328 - 2811-000009-23 : Related to resident elopement.
- Intake: #00020745 - 2811-000010-23: Reporting and complaint

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Required Programs

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the Fall Prevention and Management Policy was complied with for a resident .

As a required program, O. Reg. 246/22 s. 53 (1) 1 requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg. 246/22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the licensee's Falls Prevention and Management, Policy # 11.00.00 (revised: November 2022).

**Rationale and Summary:**

According to the above-noted policy, registered staff were required to complete the Scott Fall Risk Assessment annually, after a fall, and when there is a significant change in health status.

The Scott Falls Risk Assessment, when completed, generates a resident-specific score that corresponds with a fall risk level, which informs the development of a resident's plan of care for the purpose of preventing and managing fall risks.

The resident's clinical records identified that there was a history of falls. However, there was no indication that this resident had been assessed using the Scott Falls Risk Assessment after they had fallen as required by the licensee's policy.

During an Interview, the Manager of Nursing Care Operations (MNCO), indicated that the Scott Fall Risk Assessments for this resident was not completed after they had fallen if it is not in the point-click care.

Interviews with the Director of Care (DOC) and MNCO indicated that the Scott Fall Risk Assessment was supposed to completed after each fall.

Failure to complete a Scott Falls Risk Assessment after the resident had fallen, as per policy, puts the resident at risk for potential delay in receiving an assessment and interventions to prevent future falls.

**Sources**: Resident clinical record, the licensee's policy titled Falls Prevention and Management (policy #11.00.00, revised: November 2022), interviews with the DOC and MNCO. [705004]

## WRITTEN NOTIFICATION: Required Programs

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 53 (1) 2.

The home has failed to ensure that the skin and wound care policy program to promote skin integrity was implemented by staff and communicated to registered staff regarding skin integrity of a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the strategies outlined in the Master Care Pan, Routine Interventions for all Residents that are put in place are complied with.

Specifically, staff did not comply with the policy "Master Care Plan", which is part of the licensee's Resident care Program by reporting to registered staff regarding changes in the resident's skin.

**Rationale and Summary:**

Review of homes policy last reviewed June 2018 (RC 2.00.00, Policy: Master Care Plan, Procedure: Routine Interventions), indicates that staff are to alert the nurse to abnormal findings relating to skin integrity.

Progress notes indicated that resident's substitute decision maker (SDM) reported to nursing staff upon admission that the resident had a history of skin issues.

Review of point of care (POC) indicated that residents skin was monitored each shift by PSW staff. After review of the legend for POC skin assessment documentation survey report, PSW staff documented the following that resident had altered skin integrity.

Review of the homes policy (RC 2.00.00, Policy: Master Care Plan, Procedure: Routine Interventions), indicates that staff are to alert the nurse to abnormal findings relating to skin integrity.

A PSW reported that PSW's are to document observations related to skin of residents in POC and are also required to notify the nurse.

A RN reported that PSW staff are required to verbally report any noted changes directly to nursing staff.

The Director of Care (DOC) reported that PSW staff are required to document changes noticed in POC and verbally report to nursing staff.

Because the PSW staff failed to comply with the homes policy on reporting to registered staff when there was changes to the resident skin integrity the resident was at risk for skin breakdown.

**Sources:** Progress Notes, POC, RC 2.00.00, Policy: Master Care Plan, Procedure: Routine Interventions, Interview with PSW, RN and DOC. [742466]

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