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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 13, 2023

Inspection Number: 2023-1301-0003

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**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.07.13 14:30:46 -04'00'

Additional Inspector(s)
Margaret Beamish (000723)
Marko Punzalan (742406)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 22, 2023
The inspection occurred offsite on the following date(s): June 21, 2023

The following intake(s) were inspected:

- Intake: #00086681 -2811-000016-23 Unexplained bruising of resident. Suspected improper use of lift by staff.
- Intake: #00088053 -2811-000017-23 Unexpected death of resident.
- Intake: #00088574 -2811-000018-23 - Fall of resident resulting in change of condition.
- Intake: #00088604 -IL-13499-OT Coroner complaint regarding death of resident.
- Intake: #00089571 -2811-000020-23 Fall of resident resulting in change of condition.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee failed to ensure that an unexpected death of a resident was reported to the Director immediately.

Rationale and summary.
Critical Incident #2811-000017-23 regarding the unexpected death of a resident was not submitted to the Director until the day after it occurred. Per the Director of Care (DOC), the Registered Practical Nurse (RPN) who responded to the resident's death, should have notified DOC on on the day it occurred so they could complete a critical incident report that day. The DOC stated they became aware of the resident's unexpected death through the incident report, completed by the RPN, the day after it occurred. Per the DOC, an unexpected death of a resident must be reported to the Director immediately.

Sources:
CI #2811-000017-23;
Interview with the DOC.

[740785]

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