Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: February 5, 2024	
Inspection Number: 2024-1301-0001	
Inspection Type: Complaint	
Licensee: The Glebe Centre Incorporated	
Long Term Care Home and City: Glebe Centre, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 17-19 and 22, 2024

The following intakes were completed in this complaint inspection:

- Intake: #00095929 - Care concerns, communication and response system and allegations of abuse and neglect related to a resident
- Intake: #00106442 - Communication and response system concerns related to a resident

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

Infection Prevention and Control
Resident Care and Support Services
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care.

Rationale and Summary

Director of Care (DOC) indicated that a resident had hourly rounding initiated in December 2023 and that hourly rounding sheets are filled out to confirm checks are being completed by staff.

Inspector #720492 reviewed the resident's health care records, including the written plan of care and Kardex. The resident's written plan of care did not indicate that hourly rounding checks were required, and the resident's Kardex indicated that staff are to check and document on the Restraint Monitoring Record every hour to ensure safety.

The DOC confirmed in an interview that the resident did not have a restraint and that the written plan of care should have directed staff to provide resident with hourly rounding checks for comfort needs and that this would be updated for the resident

as it was unclear and inaccurate.

Failure to ensure the resident's written plan of care and Kardex provided clear direction to the staff and the purpose for hourly rounding checks put the resident at risk of care and comfort needs not being met.

Sources: Resident's health care records, and interviews with the Director of Care and other staff.

[720492]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident when hourly rounding was not completed as specified in the plan.

Rationale and Summary

The Director of Care (DOC) stated that hourly rounding was initiated for the resident in December 2023, and every two hours between 2400-0700 hours.

Review of video surveillance for the resident by inspector #720492 confirmed that

on a date in January 2024 between 2400 hours and 0252 hours, the resident was not checked by staff on the unit, therefore, hourly rounding was not completed as required.

Interview with the Building Systems Coordinator and the DOC confirmed that no staff entered the resident's room as required between 2400-0252 hours in January 2024.

Failure to complete hourly rounding puts the resident at increased risk of their care needs not being met.

Sources: Surveillance footage on a specific date in January 2024, the resident's health record review, and interviews with the Building Systems Coordinator, the DOC and others.

[720492]

WRITTEN NOTIFICATION: Plan of care - Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented as required.

Rationale and Summary

The Director of Care (DOC) indicated that the resident had hourly rounding initiated in December 2023 and that hourly rounding sheets are filled out to confirm checks are being completed by staff.

Inspector #720492 observed the hourly rounding sheet outside of the resident's room in January 2024. The hourly rounding sheet was not signed for 0701-0800 and 0801-0900 hours.

A Personal Support Worker (PSW) walked up to the hourly rounding sheet during the inspector's observation and signed from 0701-1100 hours. The PSW confirmed that the hourly rounding sheet is required to be filled out after the resident is checked and that this was not completed correctly.

The DOC confirmed in an interview that staff are required to complete the resident check and immediately document on the hourly rounding sheet that it was completed.

Sources: The resident's hourly rounding sheet on a date in January 2024, and interviews with a PSW, the DOC and other staff.

[720492]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the

information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary

Progress notes in Point Click Care (PCC) by a Registered Nurse (RN) in January 2024 for the resident indicated that the resident called staff for assistance with their medical treatment, but no staff came as a result of an error with the call bell system, and the resident then called 911 for help. Ambulance arrived and saw the resident.

Review of video surveillance for the resident by Inspector #720492 confirmed that on a date in January 2024 between 2400 hours and 0252 hours, no staff entered the resident’s room.

Review of the resident-staff communication and response system (RSCRS) records confirm that the resident's attempts to use the RSCRS to make a call for help failed and the staff were not notified. This was a direct result of staff failing to follow operational requirements related to the RSCRS. The Building Systems Coordinator confirmed the details of the incident in January 2024 related to the RSCRS records.

The Director of Care confirmed notification of the incident the same day and that no Critical Incident Report (CIR) was submitted.

Sources: The resident's health care record, video surveillance, RSCRS records, and interviews with the DOC, the Building Systems Coordinator and others.

[720492]

WRITTEN NOTIFICATION: Communication and response system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home is equipped with a resident staff communication and response system (RSRCS) that can be easily seen, accessed and used by residents, staff and visitors at all times.

Rationale and Summary

At the time of the inspection, the home was equipped with an RSCRS that only provided residents a means to call for assistance by pressing a button on a wearable device that could be worn by residents on a wristband, attached to clothing, or on a lanyard. Calls made by pressing the button went to cell phones carried by staff and there was an audible noise from the phone to alert staff to look at the RSCRS notification. When the button was pressed, a red light on the device flashed to demonstrate that the device had been activated. The RSCRS allowed staff to track the location of the device.

Review of a resident's progress notes in Point Click Care (PCC) indicated that during the night shift on a specific date in January 2024, the resident attempted to call staff for assistance using their RSCRS device. No staff came to assist the resident. The resident then used their telephone to call 911. Video surveillance footage confirmed that paramedics were assisted to the resident's room by an RN to see the resident.

RSCRS records confirmed that the calls that the resident tried to make to staff on that specific date in January 2024 did not go through to the staff phones. It was determined that this was a direct result of staff failing to follow operational requirements related to the RSCRS. Specifically, it was determined that the resident had made a call to staff with their RSCRS device during the evening shift. The call was not cleared by staff within the RSCRS and therefore the RSCRS device could not be used by the resident to make a subsequent call for assistance. The resident had no way to know that their RSCRS device was not generating calls due to a previous call that had not been cleared. The Building Systems Coordinator confirmed the details of the incident related to the RSCRS audit records. The resident could not use the RSCRS to call for assistance on that night in January 2024.

In January 2024, a resident was observed sitting in a common area on the 6th floor unit. Inspector #720492 could not locate an RSCRS device on the resident. A Personal Service Worker (PSW) was unable to locate the residents assigned RSCRS device. From 1335-1348 hours, two PSW staff attempted to locate the resident's RSCRS device in the resident's room where the tracker indicated it was located. The device could not be located, and the resident did not have an alternate way to call staff for assistance. The resident could not use the RSCRS as there was no RSCRS device available to them.

In January 2024, the resident was observed in a dining room eating lunch. Inspector

#720492 could not locate an RSCRS device on the resident. Inspector #720492 was informed by staff that the resident had lost three RSCRS devices in the past three days and currently did not have one. The resident had not been provided with an alternate means to call staff for assistance. The resident could not use the RSCRS as there was no RSCRS device available to them.

In January 2024, inspector #720492 observed another resident in a dining room finishing breakfast. Inspector #720492 could not locate an RSCRS device on the resident. The inspector then asked a PSW for assistance with searching for the resident's device. The PSW stated that the resident did not like having the device on their wrist. The resident did not have an alternate means to call staff for assistance. The resident could not use the RSCRS as there was no RSCRS device available to them.

In January 2024, Inspector #720492 was in a dining room observing breakfast service and the following occurred:

The button was pressed on resident #005's RSCRS wrist device. The red light flashed. PSW staff in the dining room did not receive a notification to their phones for this resident.
The button was pressed on resident #006's RSCRS wrist device. The red light flashed. PSW staff in the dining room did not receive a notification to their phones for this resident.
The button was pressed on resident #007's RSCRS wrist device. Inspector #720492 noticed that no red light flashed. PSW staff did not receive a notification to their phones for this resident
The button was pressed on resident #008's RSCRS wrist device. PSW staff did not receive a notification to their phones for this resident confirmed by inspector #720492. The inspector observed that when the button on the device was pressed,

there was no red light to demonstrate that the device had been activated. The PSW stated that the RSCRS device must not be charged.
Residents #005, #006, #007 and #008 could not use their RSCRS devices as they did not function to make a call for assistance.

As such, the home is not equipped with an RSCRS that can be easily seen, accessed, and used by residents, staff, and visitors. This poses a significant risk to resident health and safety as the ability for all users to make a call for assistance when needed, cannot be assured.

Sources: Resident's progress notes in PCC, review of RSCRS audit records, video surveillance footage in January 2024, observations of residents' and staff RSCRS system and devices, interviews with PSW's and the Building Systems Coordinator.

[720492]

WRITTEN NOTIFICATION: Communication and response system

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (c)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(c) allows calls to be cancelled only at the point of activation;

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that allows calls to be cancelled only at the point of activation.

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

Rationale and Summary

In January 2024, Inspector #720492 activated a resident's RSCRS device on their wrist while in their bedroom, and a call was successfully made to a PSW's phone. The point of activation was therefore the resident wearing the RSCRS device. The PSW was able to clear the residents' call for assistance from their phone while in a common area on the unit. The PSW did not have to go to the residents' bedroom or be in close proximity to the resident to cancel the call.

The Building Systems Coordinator (BSC) indicated that the RSCRS calls are equipped to be cancelled only within six feet or less of the point of activation, and not out of proximity of the resident.

Failure to ensure that the home's RSCRS allows for calls to be cancelled at the point of activation only, creates the risk that calls could be cancelled by direct care nursing staff without first determining why a resident, other staff, or a visitor had called for assistance. This creates the possibility that care and assistance would not be provided when it is necessary and poses a significant risk to resident health and safety.

Sources: Observation of a resident and PSW's RSCRS system and devices and an interview with the BSC.

[720492]

WRITTEN NOTIFICATION: Communication and response system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)

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

Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary

At the time of the inspection, the home was equipped with an RSCRS whereby calls made by residents from their wearable RSCRs devices went to phones that all care staff were to carry at all times. When a call was received by a phone, there was to be an audible noise to alert staff to look at the RSCRS notification. The RSCRS did not include visual indicators to alert staff to a call from a resident from the wearable devices.

In January 2024, inspector #720492 observed a resident wearing an RSCRS device on their wrist. Once activated, the inspector asked a PSW to show the inspector their phone. It was observed that the call from the resident had gone through to the phone, yet there was no audible sound from the phone to alert the PSW to the call. The sound had been turned off on the phone. The PSW showed the inspector they could turn the sound back on and did so. The inspector made a subsequent call from the resident's RSCR device. This time, the PSW's phone did emit an audible sound and the PSW was notified in this way of the call. Inspector #720492 observed during the interaction that staff cannot turn notifications off but they can silence the

sound on the phone for resident RSCRS calls for assistance.

The Building Systems Coordinator indicated that the volume on the RSCRS device used by staff can be turned down or off and there is no way to override this function.

As such, while the home is equipped with an RSCRS that uses sound to alert staff, the licensee can not ensure that the system will always have sound. This poses significant risk to resident safety and risk of delayed staff response or no staff response to calls for assistance made by residents.

Sources: Observation of resident and PSW's RSCRS system and devices, and an interview with the BSC.

[720492]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control. Specifically, the licensee failed to ensure staff used appropriate personal protective equipment (PPE) in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April

2022". The staff did not don and doff required Personal Protective Equipment (PPE) properly as per additional requirement 9.1 (f) related to additional precautions under the IPAC standard.

Rationale and Summary

In January 2024, a PSW was observed inside a resident's room without a gown or gloves where the resident was placed on droplet contact precautions. The PSW exited the room without performing hand hygiene.

The PSW admitted that they had not followed the proper donning and doffing procedures including hand hygiene as required. The staff clarified that they were supposed to wear gowns and gloves before entering any resident rooms on droplet and contact precautions and proceeded to perform hand hygiene at that time.

DOC / acting IPAC lead acknowledged that the staff were expected to follow PPE guidance when entering a resident room on droplet and contact precautions and were aware of appropriate donning and doffing procedures and hand hygiene when entering and exiting a resident room.

There was risk of infectious disease transmission when the correct donning and doffing Personal Protective Equipment (PPE) procedures were not followed.

Sources: Observations, IPAC Standard for LTCH's last revised April 2022, interviews with a PSW and the IPAC lead.

[720492]