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

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Public Report

Report Issue Date: August 25, 2025
Inspection Number: 2025-1301-0006
Inspection Type: Complaint Critical Incident
Licensee: The Glebe Centre Incorporated
Long Term Care Home and City: Glebe Centre, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 18-22, and 25, 2025.

The following Critical Incident (CI) intake(s) were inspected:

- Intake: #00152136 related to alleged physical/verbal abuse between residents.

The following complaint intake(s) were inspected:

- Intake: #00152308 related to concerns with continence care.

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

Continence Care
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 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 ensure that the Infection Prevention and Control (IPAC) standard 9.1 (d) issued by the Director, defined as: 9.1 The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include: d) Proper use of PPE, including appropriate selection, application, removal, and disposal; was followed by staff members.

Specifically, on a date in May 2025, two staff members were observed to be performing direct care for a resident while not wearing the full recommended personal protective equipment (PPE).

Sources: Video recording, review of resident medical record, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (rev. Sept. 2023), Public Health Ontario Provincial Infectious Diseases Advisory Committee (PIDAC) Routine practices and additional precautions in all health care settings (rev. June 2025), interviews with staff.

WRITTEN NOTIFICATION: Personal items and personal aids

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (b)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(b) cleaned as required.

The licensee has failed to ensure that a resident's personal items were appropriately cleaned as required. Specifically, on a date in May 2025 and on a date in August 2025, articles of a residents personal clothing that were heavily soiled were not rinsed by staff before being placed in a clothing hamper, as expected. The soiled clothing items were then found by a family member over a day later in the resident's hamper.

Sources: Photographs of clothing items, interviews with staff.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions

are documented.

The licensee has failed to ensure that actions were taken to respond to the needs of a resident when they were demonstrating responsive behaviors and that the resident's responses to interventions are documented.

The Director was informed of an incident of alleged verbal and physical abuse between two residents occurring on a date in July 2025. During interviews of five staff members, all staff acknowledged that one of the residents involved had a longstanding history of verbal and physical responsive behaviours. Review of the resident's medical record did not reveal documentation to indicate that actions had been taken to respond to the needs of the resident or the resident's response to those actions.

Sources: Review of resident clinical record, observation, and interviews with staff.

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 the Director was immediately notified of an allegation of resident to resident abuse. Specifically, when an alleged incident of

verbal and physical abuse occurred between two residents on a date in July 2025, the Ministry after hours action line was not contacted, and a critical incident report was not submitted until six days later.

Sources: Review of resident clinical record, Critical Incident report, and interviews with staff.