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

Public Report

Report Issue Date: April 2, 2026

Inspection Number: 2026-1301-0001

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: The Glebe Centre Incorporated

Long Term Care Home and City: Glebe Centre, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 5, 6, 9, 10-13 and 16-18, 2026
The inspection occurred offsite on the following dates: March 30, 2026
The following intakes were inspected:

- Intake: #00164582 -Follow-up #: 1 to CO #001 issued in 2025-1301-0009, related to r. 20 (d), Communication and Response System, with a CDD of January 30, 2026.
- Intake: #00166599 -Follow-up #: 1 - O. Reg. 246/22 - s. 272 CMOH requirements for high touch surfaces cleaned and disinfected twice daily during outbreaks. CDD February 10, 2026.
- Intake: #00170481 - Complaint with concerns regarding a resident's plan of care, alleged neglect, severe dehydration, wound care and documentation.
- Intake: #00170825 - Resident to resident physical/verbal abuse
- Intake: #00170890 - Acute respiratory infection- Outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1301-0010 related to O. Reg. 246/22, s. 272 inspected by Lisa Kluke (000725)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2025-1301-0009 related to O. Reg. 246/22, s. 20 (d) inspected by Lisa Kluke (000725)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

Compliance Order (CO) #001 from inspection 2026-1301-0001 remains non-compliant. Under O. Reg. 246/22, s. 20(d), the licensee must ensure the home is equipped with a fully functional Resident-Staff Communication and Response System (RSCRS) at each bed, toilet, bath, and shower by a specific day in January 2026. The licensee was required to implement a plan confirming RSCRS functionality and monitoring of all fixed and wearable components.

The home's policy, titled Call Alert System, was last revised December 2025, indicated that all staff were trained on this policy. This policy was not implemented and the compliance plan for the RSCRS functionality or monitoring failed as per the following:

1. Fixed call bell system not functional or available
• Several bedside call bells were observed missing, broken, or not attached during an RSCRS observation and testing period in March 2026.
• Maintenance audits included that these fixed devices were present and functional on a day in March 2026, however the inspectors observed they were not.
• Weekly audits failed to identify missing or damaged equipment.

2. Required reporting to maintenance not completed
• Policy requires immediate reporting of non-available or functional equipment to either the Director of Building and Infrastructure or the Director of Environmental Services.
• Management confirmed no reports or Workshub tasks were submitted for rooms

with missing or broken call bells.

3. Handheld device failures and staff workarounds
• Staff turned off devices due to frequent emergency calls identified during interviews, when emergency calls were not consistently received across home areas due to hand held device log out issues.
• Devices were observed logged out or in Do Not Disturb mode.
• Director of Care or the Director of Building and Infrastructure were unaware of these handheld device logout issues.

4. Training plan not implemented
• Not all nursing staff were trained. Training was informal, inconsistent, and lacked documentation.
• Training did not address that a) handheld devices should remain logged in for their entire shift, b) registered nursing staff dashboard verification to address when specifically each week and follow through with audits by the Director of Building and infrastructure or c) emergency call protocols for escalation to address these emergencies timely to prevent disruption to all home areas.

5. Inconsistent verification of wearables and fixed call bells
• Nursing staff had conflicting understanding of their responsibilities for public bathrooms on the first and second floors in the home and the worship activity room as these calls were unexpected by staff.
• Personal support staff had conflicting understanding and practices for wearable and fixed call bell verification for each resident assigned to them at the beginning of each shift.
• Registered nursing staff had conflicting understanding and practices for wearable dashboards verification (daily, weekly, or not at all), resulting in multiple low-and critically low battery for resident wearable devices. The policy does not specify the

day of the week when weekly reviews for the devices are required.

6. RSCRS were missing in required public areas
• RSCRS were unavailable in key resident areas: Main reception (when receptionist is not on duty), beauty salon, physiotherapy room.

7. Required Bi-Weekly Response-Time audits not completed
• The Director of Building and Infrastructure did not ensure IT provided response-time audits to nursing leadership as required to date.

Failures with, equipment availability and functionality, reporting issues with equipment, staff training, audits and system monitoring, prevented the home from meeting the requirements of Compliance Order #001.

Sources: Several observations throughout the home's RSCRS system; interviews with staff, record review of their compliance plan including policy and procedure, memos from the CEO to all staff, education material, staffing lists for nursing staff education, audits completed by nursing staff for wearable devices and maintenance staff for static equipment and devices, Tenera education provided to nursing staff including sign in sheets, numerous examples of their sign in and out sheets used for handheld Tenera phones, Tenera repair report.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
In the past 36 months, a CO under O.Reg. 246/22, s. 20 (d) was issued in 2025-1301-0009 on December 8, 2025 and is not complied.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

Staff did not use safe transferring and positioning lift device or techniques when assisting a resident. On a day in March 2026, a staff did not transfer a resident with the assessed full mechanical lift device. The resident's plan of care indicated physiotherapy assessed the resident to use full mechanical lift for all transfers.

Sources: Inspector observations, interviews with staff members, resident health records and policy and procedures.

WRITTEN NOTIFICATION: Nutrition and Hydration

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

In accordance with 11 (1) b, the home is required to ensure that the policy is complied with.
On three consecutive days in January 2026, a residents' fluid intake fell below 1000ml daily and a dehydration risk assessment was not completed per the homes hydration policy. During an interview with a staff member, they confirmed that the Registered Nursing staff did not complete the nightly fluid audits, thus not completing the dehydration risk assessment that would have been triggered.

Sources: Interview with a staff member, homes nutrition and hydration policy and

resident record review.

WRITTEN NOTIFICATION: Dining and Snack Services

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 4.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences was not completed.
On a day in March 2026, a resident received cream of mushroom soup however, the resident has a lactose intolerance and an allergy to mushrooms and therefore this menu option was contraindicated. Staff confirmed that the mushroom allergy was not included in the binder, located in the servery prior to a date in March 2026, that includes all special needs and recommendation of each resident.

Sources: Resident record review and an interview with staff.

WRITTEN NOTIFICATION: Medication Management System

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-

based practices and, if there are none, in accordance with prevailing practices; and

The written medication management system policies and protocols were not implemented in accordance with evidence-based practices.
In accordance with the homes medication administration policy, the registered staff are required to observe the resident taking the medication.
On a day in March 2026, a staff dispensed a resident's medication and brought it to the resident's room to have the Power of Attorney (POA) administer it. They did not observe the medication being taken.
During an interview with staff, they confirmed that they are expected to observe the medication being taken by the resident.

In accordance with the homes medication administration policy, the registered staff are required to administer medications within a one hour window of the scheduled medication time.
During an observation, on a day in March 2026, a registered staff attempted to administer a specific medication at 1224 hours. The medication was refused and the staff stated to the family that they had forgotten to give the medication to the resident. During a record review, it was documented that the staff administered the scheduled 1100 hours medication, at 1:22pm. at 1322 hours.

On a day in January 2026, a resident continued to received a specific medication prior to a reassessment by a medical doctor. A physician had specified that the order required a reassessment prior to being continued.
In accordance with the homes medication administration policy, they are required to ensure that orders are verified and properly prescribed on the electronic medication system (eMar).

Sources: Observation, resident record review and interviews with staff.

WRITTEN NOTIFICATION: Security of drug supply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
2. Access to these areas shall be restricted to,
i. persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.

Steps were not taken to ensure the security of the drug supply when registered staff did not restrict access by a non registered staff, to a specific home area medication room.

On a day in March 2026, a non registered staff requested the registered staff to unlock the door to the medication room on a specific unit, to provide them access to complete some work inside the medication room. The registered staff did not stay with the non registered staff. The non registered staff was not a person that can dispense, prescribe or administer drugs in the home and therefore, was not permitted in the medication room without being observed.

Sources: Observations, review of signage posted on the medication room door and interviews with staff.

COMPLIANCE ORDER CO #001 Plan of care

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Provide training to all nursing staff that work on a specific home area:
a)regarding the process for collecting a urine sample and sending it to the laboratory
b) regarding the process for receiving urine sample results from the laboratory and actions to take if there should be a delay.
2.Documentation shall be kept regarding all actions in this order until the Ministry of Long Term Care identifies this order as complied.

Grounds

The licensee shall ensure that the staff involved in the different aspects of care of the resident collaborate with each other.
On a day in January 2026, a sample was obtained to rule out infection involving a resident. On a day in February 2026, the home was notified by the Substitute Decision Maker that the results had been made available on a earlier day in February 2026. During an interview with staff, they confirmed that the results typically arrive back in two to four days. If they do not receive the results, the home would then place a call to the laboratory (Lab). Following a call to the Lab, the home

obtained the results on a later day in February 2026 and appropriate treatment was initiated. The staff acknowledged that there had been a seven day delay from when the sample was collected to when the results were received.

Sources: Resident record review, interview with staff.

This order must be complied with by April 17, 2026

COMPLIANCE ORDER CO #002 Prohibited devices that limit movement

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 121 5.
Prohibited devices that limit movement
s. 121. For the purposes of section 38 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
5. Any device used to restrain a resident to a commode or toilet.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1.Stop using prohibited lift devices while toileting residents.
2.Review and revise the home's training for performing a lift and post-lift considerations, to ensure this annual training includes reasons why devices are removed from residents after the transfer is complete.
3.Provide training to all nursing staff that work on a specific home area:
a)regarding performing a lift and post-lift considerations as indicated in #2.
b)regarding what is considered a prohibited device. This training shall include FLTCA, 2021, s. 38 and O.Reg. 246/22, s. 121.

3.Documentation shall be kept regarding all actions in this order.

Grounds

A device was used to restrain a resident to a seating device for toileting. On a day in March 2026, a resident was observed seated on a shower chair over a receptacle for toileting needs, wearing a transferring device that was attached to a mechanical device, which had the effect to limit or inhibit the resident's freedom of movement. Staff indicated this transferring device was placed in front of the resident to prevent falls while they left the resident unattended in the shower room to assist other residents.

Sources: Observation of resident in the shower room, interviews with staff and resident health care records.

This order must be complied with by May 15, 2026

COMPLIANCE ORDER CO #003 Maintenance services

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:
1.Develop and implement written schedules and procedures for routine, preventative and remedial maintenance of the Resident Staff Communication and Response System (RSCRS) used in the home.

Grounds

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the home did not ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance of the home's Tenera Resident Staff Communication and Response System (RSCRS).

On a day in March 2026, staff indicated the Tenera RSCRS was not part of the preventative schedules in the home. The staff stated that they oversee this system and rely solely on their own knowledge for all routine, preventative or remedial tasks related to this electrical equipment.
Another staff indicated the RSCRS is part of the services in the home, and that both staff work under a specific service department.

Sources: Interviews with staff.

This order must be complied with by May 15, 2026

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.