Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 5, 2019	2019_683126_0030	018878-19, 019978-19, 019997-19	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

Long-Term Care Home/Foyer de soins de longue durée

The Salvation Army Ottawa Grace Manor
1156 Wellington Street OTTAWA ON K1Y 2Z3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LINDA HARKINS (126), LISA CUMMINGS (756)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19, 20, 21, 22, 25, 2019.

During this inspection the following logs were inspected:
Log #018878-19, Critical Incident (CI) # 2873-000032-19 related to an Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
Log #019978-19, CI #2873-000035-19 related to an emergency, including fire, unplanned evacuation or intake of evacuees.
Log #019997-19, CI #2873-000036-19 related to an allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Director of Operations, the Environmental Manager, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and several residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the Director was immediately notified of an incident of fire in the elevator room.

A Critical Incident (CI) #2873-000035-19 was submitted on a specific date of October 2019 related to a fire in the elevator room.

Discussion held with DOC #100 who indicated that they requested to Registered Nurse (RN) #109 to call the after-hours number to report the incident to the Director

Discussion held with RN #109 who indicated that they had not contacted the after-hours number to notify the Director of the incident of fire.

The licensee did not immediately notify the Director of the fire that occurred on that specific date of 2019. [s. 107. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is immediately notified on an incident of fire, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Emergency Plan (EP) of the home related to code red was evaluated and updated annually.

A Critical Incident (CI) #2873-000035-19 was submitted on a specific date of October 2019 related to a fire in the elevator room.

The EP related to fire (Code red) was reviewed and it was noted that the Code Red section was last reviewed on August 2018.

Discussion held with DOC #100 who indicated that the revision of the ER was planned for 2021 and that the evaluation and update EP was to be completed by the Director of Operations.

Discussion held with the new Director of Operations #106 who indicated that he/she was not aware that the EP required to be evaluated and updated annually.

The licensee failed to evaluate and update the EP annually. [s. 230. (6)]

Issued on this 16th day of December, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.