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
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Original Public Report

Report Issue Date: May 31, 2024	
Inspection Number: 2024-1358-0001	
Inspection Type: Complaint Critical Incident	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: The Salvation Army Ottawa Grace Manor, Ottawa	
Lead Inspector Pamela Finnikin (720492)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-10 and 14-16, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00102033 - CI #2873-000007-23; Intake: #00103211 - CI #2873-000008-23 - residents with injury resulting in transfer to hospital

The following intakes were completed in this complaint inspection:

- Intake: #00113917 - Related to care concerns of a resident

The following Inspection Protocols were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary

Review of the Critical Incident Report (CIR) and attached files submitted to the Director in April 2024 confirmed that an email was received by the home regarding multiple care concerns of a resident.

The Director of Care (DOC) acknowledged that this complaint regarding the care of the resident was received in writing and should have been immediately forwarded to the Director.

Failing to immediately inform the Director of this complaint posed a risk that the complaint was not immediately investigated.

Sources: Email correspondence from complainant, review of CIR submitted in April 2024 and interview with the DOC.

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WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

As a required program, O. Reg. 246 / 22 s. 53 (1) required the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury.

In accordance with O. Reg. 246 / 22, s. 11 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or strategy in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, staff did not comply with the policy titled Fall Prevention and Management Program, Policy #F23 (revised July 2020) which was included in the licensee's Fall Prevention and Management Program.

Rationale and Summary

#1

A Critical Incident Report (CIR) confirmed that a resident had an unwitnessed fall in November 2023 resulting in a transfer to the hospital with an injury.

Page 8 of the Falls Prevention and Management Program policy states under Section 1.5 Fall and Post Fall Assessment and Management, Subsection Registered Nursing Staff Point five to Initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy.

Record review completed for the resident confirmed that no post-fall head injury routine was initiated for the resident's November 2023 fall prior to being transferred to the hospital with an over 60 minute wait for the ambulance.

Page 8 of the Falls Prevention and Management Program policy states under Section 1.5 Fall and Post Fall Assessment and Management, Subsection Registered Nursing Staff point four stated Notify the attending physician, Power of Attorney (Substitute Decision-Maker (SDM) of the fall, interventions and status of the resident.

Review of progress notes for the resident in December 2023 from a Registered Practical Nurse (RPN) indicated that the SDM was not notified of the fall in November 2023.

An RPN and a Registered Nurse (RN) confirmed in interviews that the Fall Prevention and Management Program, Policy #F23 was not followed for resident's November 2023 fall, and that a HIR was not completed and that the SDM was not notified after the fall as per policy.

The resident was at a moderate risk for falls. Failure to complete a HIR as per policy could delay identifying risk factors and injuries, and impede required falls prevention interventions to mitigate the risk of falls. Failure to notify the SDM puts the resident at risk of uninformed care decisions made or not made by the SDM.

Sources: Record review for the resident, the CIR, Fall Prevention and Management Program Policy #F23, interviews with an RPN, RN and others.

#2

Progress notes and the risk management post fall incident report was reviewed for the resident which confirmed that the resident had an unwitnessed fall which occurred in October 2023 and the Head Injury Routine (HIR) was initiated.

Page 8 of the Falls Prevention and Management Program policy states under Section 1.5 Fall and Post Fall Assessment and Management, Subsection Registered Nursing Staff point six stated Monitor vital signs according the Head Injury Routine and point seven Head Injury Routine as follows: Initial Vitals: First vitals - time of fall, second vitals - thirty minutes, third vitals - thirty minutes, fourth vitals - one hour, fifth vitals - one hour, sixth vitals - one hour then every shift for seventy-two hours. Assess post fall for signs of neurological changes by assessing hand grips and size of pupils. Look for any facial droop, behavior changes, and weakness on one side.

Review of the resident's HIR document on a specific date in October 2023

confirmed the HIR was initiated. HIR was not followed as per policy for fourth, fifth and sixth vitals on a specific day in October by an RPN.

Page 8 of the Falls Prevention and Management Program policy states under Section 1.5 Fall and Post Fall Assessment and Management, Subsection Registered Nursing Staff point four stated Notify the attending physician, Power of Attorney (POA) / Substitute Decision-Maker (SDM) of the fall, interventions and status of the resident.

Review of progress notes for the resident in October 2023 from an RPN indicate that the SDM was not notified of the fall in October 2023.

An RPN and DOC confirmed in interviews that the Fall Prevention and Management Program, Policy #F23 was not followed for resident's October 2023 fall, and that a HIR was not completed and that the SDM was not notified after the fall as per policy.

The resident was at a moderate risk for falls. Failure to complete a HIR as per policy could delay identifying risk factors and injuries, and impede required falls prevention interventions to mitigate the risk of falls. Failure to notify the SDM puts the resident at risk of uninformed care decisions made or not made by the SDM.

Sources: Record review for the resident, including progress notes, HIR document, and the risk management post fall incident report, Fall Prevention and Management Program policy #F23 and interviews with an RPN and DOC.

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WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and
iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

The licensee has failed to respond to written complaints made by a complainant related to the care of a resident as required.

Rationale and Summary

The LTCH received a letter of complaint by email that outlined concerns related to the care of a resident in April 2024.

The Director of Care (DOC) stated that the complainant was responded to by email on two dates in April 2024.
Review of all correspondence provided by the complainant and response email from the DOC failed to include an explanation of what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded,

together with the reasons for the belief, and what the licensee has done to resolve the complaint including confirmation that the licensee would immediately forward the complaint to the Director, as the letter included concerns about care not being provided to the resident as per the resident's care plan.

The DOC confirmed that no further written correspondence or follow up was made to the complainant to include these requirements after the April 2024 emails.

Sources: Complaint email and response letters and interview with the DOC.

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