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: January 14, 2025
Inspection Number: 2025-1358-0001
Inspection Type: Proactive Compliance Inspection
Licensee: The Governing Council of the Salvation Army in Canada
Long Term Care Home and City: The Salvation Army Ottawa Grace Manor, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 2-3, 6, 8-10, 13, 2025

The following intake(s) were inspected:

- Intake: #00135881 - Proactive Compliance Inspection

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards

Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (e)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(e) the long-term care home's procedure for initiating complaints to the licensee;

The licensee has failed to ensure that the required information posted in the home, related to the long-term care home's procedure for initiating complaints to the licensee was posted. On January 6, 2025, the inspector did not see on the information board the home's procedure for initiating a complaint.

Sources: Observation of the information board.

On January 8, 2025, the inspector observed the Assistant Director of care (ADOC) posting the complaint policy and procedure on the information board with the forms to be filled out.

Date Remedy Implemented: January 8, 2025

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246 / 22, s. 35 (3) (a)
Nursing and personal support services
s. 35 (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

The licensee has failed to ensure that its staffing plan provided for a staffing mix that meets the requirements as required by the Fixing Long-Term Care Home Act, 2021, and Ontario Regulation 246 / 22. Specifically, the home's staffing plan allowed for a Registered Practical Nurse (RPN), in exceptional circumstances, to replace a Registered Nurse (RN) if an RN was unavailable and an RN was available on call. Ontario Regulation 246 / 22 s. 49 3., which previously allowed for an RPN to replace an RN if an RN was available for consultation, was revoked as of July 1, 2024.

Sources:
The home's staffing plan and revised staffing plan.

During the inspection on January 6, 2025, the home's staffing plan was revised by the Director of Care (DOC), and reviewed by the inspector, to state that a Registered Nurse (RN) must always be replaced by an RN, or the Assistant Director of Care (ADOC) if an RN was unavailable, and that a Registered Practical Nurse (RPN) cannot replace an RN.

Date Remedy Implemented: January 6, 2025

WRITTEN NOTIFICATION: Residents' Council - Duty to respond

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that when the Resident's Council raised concerns or recommendations, they were responded to in writing within 10 days of receiving the advice.

Specifically, the Residents' Council raised operational concerns during their meetings, as recorded in the meeting minutes, in the months of January, February, April, May, June, July, August, September, October and November 2024. Only one written response to an operational concern, in February 2024, was provided to the Residents' Council.

Sources: Residents' council meeting minutes, interviews with the DOC and a resident.

WRITTEN NOTIFICATION: Doors in the home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not supervised by staff. Specifically, the licensee has failed to ensure that the doors to the laundry rooms on the Wellington and Gladstone units were kept closed and locked when not being supervised by staff. During the inspection, the inspector observed the laundry rooms being open on three occasions, without any direct staff supervision, on different dates and units during the inspection. Neither room appeared appropriate for unsupervised resident access and the Director of Operations confirmed, in their interview with the inspector, that unit laundry rooms are to be closed and locked when not in use by a staff member.

Sources:
Observations of the laundry room doors on Wellington and Gladstone units;
Interview with the Director of Operations.

WRITTEN NOTIFICATION: Pain management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to ensure that the documentation of the monitoring of a resident's response to, and effectiveness of, the pain management strategies were documented. Per Ontario Regulation 246 / 22 s. 11 (1) b., the licensee must have a pain management program that provides for monitoring of a resident's response to, and effectiveness of, the pain management strategies, and that they comply with that policy. According to Policy E 32: Pain Management Program, registered nursing staff are to document the effectiveness of pain management interventions. The ADOC failed to ensure they documented the effectiveness of their pharmacologic pain management intervention for a resident.

Sources:
Policy E 32: Pain Management Program last reviewed 2024;
A resident's electronic chart;
Interview with the ADOC.

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 1.
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:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that an area where drugs are stored was locked while not in use. Specifically, the licensee failed to ensure that the Parkdale unit medication room was locked when not in use. During the inspection, the inspector observed, on one occasion, a medication storage area door being propped open while the unit RPN was performing a mealtime medication pass and was not using the room, further no staff were directly supervising the open medication room.

Source:
Observation of the Parkdale medication room door during the inspection.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 168 (2) 6. v.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family

Council, if any, and members of the staff of the home.

The licensee has failed to ensure that the date of when the Continuous Quality Improvement (CQI) report was provided to the Family and Residents' Council was recorded in the CQI report.

Sources:
Review of the home's CQI report for 2023-2024;
Interview with the DOC

WRITTEN NOTIFICATION: Emergency plans

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 268 (4) 1. ix.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
ix. loss of one or more essential services,

The licensee has failed to ensure the emergency plans provide for the following: dealing with emergencies including loss of one or more essential services, specifically heat loss in the home.

Sources:
Record review of the home's emergency plans;
Interview with the Director of Operations.

WRITTEN NOTIFICATION: Emergency plans - Written record of testing

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 268 (10) (d)
Emergency plans
s. 268 (10) The licensee shall,
(d) keep a written record of the testing of the emergency plans and planned evacuation and of the changes made to improve the plans.

The licensee has failed to ensure that written records were kept of the annual testing of the emergency plans for loss of essential services, fires, gas leaks, natural disasters, boil water advisories, outbreaks of a communicable disease or disease of public health significance, epidemics, pandemics, and floods, as required by Ontario Regulation 246 / 22 s. 268 (10) (a), for the 2024 year and of any changes made to improve the plans.

Sources:
Record review request for the home's written record of the testing of emergency plans and improvements to the plans based on the testing;
The home's written record of testing of their emergency plans for missing residents, medical emergencies, violent outbursts, and extreme weather events;
Interview with the Director of Operations.

WRITTEN NOTIFICATION: Website - Continuous quality improvement initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 271 (1) (e)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(e) the current report required under subsection 168 (1);

The licensee has failed to ensure that the home's website included the current report for the home's continuous quality improvement initiative.

Sources:
The home's website www.gracemanor.ca;
Interview with the DOC.

COMPLIANCE ORDER CO #001 Training

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 82 (2) 8.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
8. Emergency and evacuation procedures.

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

A) Finalize and implement a written heat loss emergency plan and train all staff, including management, on their relevant roles and responsibilities in the plan;
B) Develop a process to ensure that all staff, including management, are annually retrained on the home's heat loss emergency plan, as required by the Fixing Long-Term Care Homes Act, 2021 s. 82 (4), beginning in the 2026 calendar year;
C) Ensure that a written record is kept of all training of staff members related to the home's heat loss emergency plan including the name, role, and date of training of each staff member trained to verify compliance with this order.

Grounds

The licensee has failed to ensure that all staff in the home receive training on emergency and evacuation procedures, specifically for training related to a heat loss event in the home, prior to performing their responsibilities in the home.
According to Ontario Regulation 246/22 s. 268 (4) (1.) (ix)., the home must have

emergency plans that provide for dealing with emergencies including the loss of one or more essential services, which includes the failure of the home's heating system, and that staff be provided training on this plan. Upon request by the inspector to the Director of Operations, the home was unable to provide a heat loss plan. During interviews with a Registered Nurse and the Director of Care, both stated that staff are not trained on their responsibilities during a loss of heating event in the home.

Sources:
Record review of the home's emergency plans;
Interviews with an RN and the DOC.

This order must be complied with by April 9, 2025

COMPLIANCE ORDER CO #002 Dining and snack service

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 5.
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:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Develop and implement a written action plan to ensure that all foods and fluids are served to residents at the minimum and maximum temperature as set by the home's food safety temperature control policy;
B) Provide training to all dietary staff who serve food on the unit regarding the action plan and relevant procedures to follow if food is not being measured at the set

minimum and maximum standard. A written record of all training must be kept which includes the names and signatures of those who were trained, and the date time of training;
C) A management team member will conduct audits, at minimum, three times per week for a period of four weeks, to ensure that food is being served at the appropriate temperature. Every audit must include a breakfast, a lunch, and a dinner from different units of the home. All home areas must be audited at minimum once per week. If any deviation from the home's food safety temperature control policies, procedures, or food temperature standards are identified during the audit, the management team member must take immediate corrective action to ensure food is meeting the home's set food temperature standard. A written record of all audits, including: date, time, location of audit, and corrective actions taken (if needed), must be kept.

Grounds

The licensee has failed to ensure that residents were provided food at a safe and palatable temperature.

The inspector reviewed the December 2024 food temperature logs on Wellington House and Queen's House units. The food temperatures for certain cold foods were found to be above the home's maximum temperature standards, as per the criteria in the home's policy, on Wellington House and Queen's House on various dates throughout December 2024. The food temperatures, for certain hot foods, were found to be below the home's minimum temperature standards on one date in December 2024 on Queen's House. In December 2024, no temperature records were kept for Wellington House for four meals or for Queen's House for two meals.

The home's policy criteria for serving hot food is a minimum of 140 degrees Fahrenheit (F) and for serving cold food is a maximum of 40F. The Food Service Manager (FSM) acknowledged that the cold food tends to be higher than 40F, and

the cold food is placed in the salad bars which is like a fridge and the temperatures are not taken a second time, even if the temperature is above the maximum range (40F).

Sources: Food temperature for the month of December 2024 for Wellington House and Queen's House, Food Safety Temperature Control Policy (FSF8), interview with the FSM.

This order must be complied with by February 21, 2025

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.