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: March 19, 2025
Inspection Number: 2025-1358-0002
Inspection Type: Critical Incident Follow up
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): March 12, 13, 14, 17, 18, 2025

The following intake(s) were inspected:
Intake: #00132982/CI #2873-000012-24 – related to Environmental Hazard.
Intake: #00135708/CI #2873-000014-24 and Intake: #00140656/CI #2873-000005-25 – related to a fall with injury and a change in condition.
Intake: #00137103 - Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 5.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2025-1358-0001 related to O. Reg. 246/22, s. 79 (1) 5.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident related to a responsive behaviour.

A resident was described as having a specific responsive behaviour. In November 2024, the resident was observed to be holding - and was suspected of ingesting, a liquid cleaning product. There were no written directions to staff in any care plan belonging to the resident at any time leading up to the incident in November 2024, or after, regarding the specific responsive behaviour.

Sources: a review of the resident's health care records, including progress notes and relevant care plans; and interviews with staff including PSW, RPN, and DOC.

WRITTEN NOTIFICATION: Hazardous substances

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times, when a resident accessed such a product in November 2024.

According to a Housekeeping Staff, the resident had accessed and potentially ingested a specific product which contained bleach in November 2024, when the staff member had responded to a commotion in the hallway outside of the resident's room. According to the staff member, the product had been taken by the resident from inside the resident's room or from the housekeeping cart for which they did not have a key, and therefore did not routinely lock.

Sources: a review of the relevant critical incident report, health care records belonging to the resident, including progress notes, and the product label for the accessible product, and related safety data sheet; and interviews with staff, including Housekeeping staff, RPN, and the Director of Operations.