Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2013	2013_198117_0016	000456, 000586,000592	Complaint

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 4, 5, and 6 2013.

It is noted that three complaint inspection logs were completed during this inspection: Log # O-000456-13, #O-000586-13 and #O-000592-13

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care (DOC), evening Charge Nurse, Registered Dietitian, several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several members of the housekeeping staff, to a dietary aide, a member of the maintenance staff, to several family members and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents, observed lunch time meal services on September 4, 5 and 6 2013, examined several identified resident rooms with focus on odour and resident clothing, examined a resident unit laundry room, reviewed the process for reporting and locating resident lost clothing and personal items, examined a unit's tub/shower room equipment, examined two resident care units dining room floors, reviewed an identified resident's dietary menu, reviewed how the home's Heating Ventilation and Air Conditioning (HVAC) functions and reviewed temperature logs for August 31 to September 5 2013, reviewed the maintenance equipment repair logs with a focus on a unit's tub/shower chairs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 3 (1) 1 in that several residents right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was not respected by two staff members. [Log # O-000586-13]

Resident #2 has some cognitive impairments and a tendency to repeat him/herself during conversations. Staff member #S103 was observed by a family member in May 2013 to say that Resident #2 is stupid because of his/her behaviours of repeating him/herself during conversations. The family member stated that the staff member's comments were disrespectful towards the resident and that this was reported to the home's management.

Resident # 4 has a wheelchair and requires one person assistance for mobilization. In August 2013, Resident #4 asked a family member to move him/her to another section of their unit. When this was noted, staff member #S103 spoke in a loud and rude manner to Resident #4 and the family member, saying "Why did you move Resident #4?! I put him/her there for a reason!". The family member reports that he/she and the resident felt that the staff member lacked courtesy and respect when speaking to them and that he/she reported this incident to the home's management.

Resident #5 has some cognitive impairments and a tendency to repeat him/herself during conversations. On September 5, 2013, Resident #5 stated to Inspector #117 that staff member #S102 is not respectful towards him/her as #S102 will often ignore his/her requests to have some tea during the meal service. On September 5, 2013, staff member #S101 stated that they had observed staff member #S102 ignore the resident's requests in the past and that they had intervened on the resident's behalf to ensure that the resident's request was met. Staff member #S104 stated on September 5, 2013, that Resident #5 often will tell him/her that #S102 is not nice because S#102 did not get him/her some tea. Staff member #S101 states that staff member #S102's lack of respect was reported to the home's management team.

Resident #6 has some cognitive and mobility impairments. On September 5 and 6, 2013, the resident stated to Inspector #117 that staff member #S102 frequently ignores his/her requests to ensure that his/her bed is made. Resident #6 stated that staff member #S102 likes "to give orders and boss the residents around". Staff members #S101 and #S104 state that Resident #6 has frequently reported to them staff member #S102's lack of respect towards him/her. Both state that this was

reported to the home's management.

On September 6, 2013, the DOC stated to Inspector #117 that in the past few months, the home's management did receive reports from some families and supervisory staff that staff members #S102 and #S103 had lacked courtesy and respect when speaking and working with several residents. The DOC states that disciplinary measures have been implemented with both staff members. [s. 3. (1) 1.]

Issued on this 12th day of September, 2013

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

Lynn Duchesne #117