Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Oct 8, 2020	2020_593573_0015	017197-20, 017272-20, 018344-20	Complaint

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

ANANDRAJ NATARAJAN (573)

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 15 - 18, 21 - 25, 2020.

The following complaint logs were inspected during this inspection:
-Log #: 017197-20 and 017272-20 related to the resident transfer to hospital
-Log #: 018344-20 related staff to resident alleged physical abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Manager of Nursing Care Operations, Director of Quality Management, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Personal Support Worker Supervisor and the resident.

In addition, the inspector reviewed resident health care records and the licensee's internal investigation notes.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that resident’s plan of care was based on an interdisciplinary assessment of the resident’s mood and behaviours.

A review of the resident’s progress notes identified that the resident had frequent changes in their mood and behaviour patterns, specifically related to their personal care.

During separate interviews with the PSWs, and the RN, they all indicated that the resident had exhibited the specified behaviour on multiple occasions.

Inspector reviewed the resident’s plan of care and identified that there was no focus, goals nor any information regarding the resident’s mood and behaviours. Furthermore, there was no information on the identified the resident’s behaviours with the specific interventions.

The RN acknowledged that the resident’s plan of care does not have the information of the resident’s mood and the specified behaviours.

Sources: The resident’s care plan and progress notes, and an interview with the RN and other staff. [s. 26. (3) 5.]

Issued on this 22nd day of October, 2020

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

Original report signed by the inspector.