Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawasao.moh@ontario.ca

Original Public Report

Report Issue Date: October 19, 2022	
Inspection Number: 2022-1301-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: The Glebe Centre Incorporated	
Long Term Care Home and City: Glebe Centre, Ottawa	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature**
Additional Inspector(s) Severn Brown (740785)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

September 26, 27, 28, 29, 30, October 4, 2022

The following intake(s) were inspected:

- Intake: #00002270- [CI: 2811-000016-22] related to a fall
- Intake: #00002496- [CI: 2811-000013-22] related to a fall
- Intake: #00006000- [CI: 2811-000020-22] related to a fall

The following intakes were completed in the Critical Incident System Inspection: Log #00001126-22, Log #00004543-22, and Log #00006867-22 related to falls.

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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawasao.moh@ontario.ca

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

Falls Prevention and Management
Infection Prevention and Control

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.*

The licensee has failed to ensure a resident's plan of care set out clear directions to staff and others who provide direct care.

Rationale and Summary
In accordance with FLTCA, 2021 s. 7406 (1) c. a resident's plan of care must set out clear directions to staff and others who provide direct care.

A resident sustained a fall which required surgical intervention. Staff indicated that a resident's fall risk status and fall prevention strategies are to be communicated in the resident's plan of care. Based on interviews with the resident has multiple fall prevention strategies in place however not all strategies are listed in the resident's plan of care. Further, staff interviews and a records review revealed that the resident's fall risk status listed in the resident's plan of care was not accurate. The resident's plan of care must indicate the resident fall risk status and fall prevention strategies to prevent falls.

Sources:
Resident's clinical record, observations and interviews with the Manager of Nursing Care Operations, a registered nurse and a personal support worker.

[740785]