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 District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: April 28, 2025
Inspection Number: 2025-1301-0004
Inspection Type: Critical Incident
Licensee: The Glebe Centre Incorporated
Long Term Care Home and City: Glebe Centre, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 22, 23, 24, 28, 2025

The following intake(s) were inspected:
- Intake: #00143576 - Unexpected death.
- Intake: #00144466 - Fall of a resident resulting in injury.

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

Resident Care and Support Services
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports Re Critical Incidents

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NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

Reports re critical incidents

s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

The licensee has failed to ensure the Director was immediately informed of a sudden and unexpected death of a resident on a day in March, 2025.

During an interview in April, 2025, a staff confirmed that the requirements to report to the Director is immediate for an incident of sudden and unexpected death of a resident.

Sources: Interview with staff and resident record review