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

Division de la responsabilisation et de la performance du système de santé
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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
Jan 24, 2014	2014_285546_0002	O-000975-13	Critical Incident System

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

SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 17 2014

for Log # O-000975-13

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), one Registered Practical Nurse (RPN), 2 Personal Support Workers (PSW) and the Programs Aide assigned to the home area.

During the course of the inspection, the inspector(s) reviewed residents' health records, reviewed CIS, observed resident care and services, observed activity program on January 17 2014, reviewed the posted Residents' Bill of Rights and reviewed the home's following policies and procedures:
* Resident Abuse and Neglect, Investigation and Reporting #RC 08.03.02 (revised October 2013);
* Responsive Behaviour, Management of a resident with severe responsive behaviours #RCM currently under revision (last revised Jan 2012);
* Responsive Behaviour, Caring for a resident with Responsive behaviours #RCM currently under revision (last revised Jan 2012);
* Wandering Behaviour - Management of unsafe wandering and elopement #HR 2.01.01 (last revised Jan. 2012).

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s.24 in that a person had reasonable grounds to suspect abuse of a resident and failed to immediately report the information to the Director.

On a specific day in October 2013, a critical incident reports that the affected resident #002 was in his/her room watching television, when (s)he saw another resident (resident #001) entering his/her room. Resident #002 reportedly raised his/her hand to indicate to the intrudent resident #001 (s)he was to leave. Resident #001 reacted by striking out at resident #002, hitting his/her upper body part with a plastic object and twisting the said upper body part. Resident #002 complained to the Charge RPN who assessed the body part and applied first aid measures. The RPN documented the incident in resident #002's electronic progress notes.

On January 17 2013, in an interview with the Director of Care, she confirmed that the nurse on duty documented the incident but did not inform management staff of the incident, nor did the RPN notify the family. Management was first informed by the resident #002's family member the next day late in the afternoon. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. After reviewing a specific critical incident and during an interview with the inspector on January 17, 2014, the Director of Care confirmed that Police were not notified as per legislation and the Home's policy and procedure (Resident Abuse and Neglect, Investigation and Reporting #RC 08.03.02 (revised October 2013)).

Therefore, the licensee failed to comply with O.Reg 79/10 s.98 in that the licensee did not immediately report a witnessed incident of abuse to a resident to the appropriate police force. [s. 98.]

Issued on this 24th day of January, 2014

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

S. Wendt