Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 3, 2010	2010_188_2811_03Sept095639	Complaint Log # O-000391

Licensee/Titulaire

The Glebe Centre
950 Bank St
Ottawa ON
K1S 5G6
Fax: (613) 238-4759

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

The Glebe Centre Incorporated
950 Bank St
Ottawa ON
K1S 5G6
Fax: (613) 238-4759

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

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the care and services provided to an identified resident.

During the course of the inspection, the inspector spoke the home's administrator; the home's director of care; the home's assistance director of care; a Registered Nurse working on September 3, 2010; to two health care aids working on September 3 2010 and to the identified resident.

During the course of the inspection, the inspector reviewed the identified resident's health care records, reviewed the resident care unit equipment cleaning schedules, reviewed the resident care unit's night time health care aid work routine directives, observed the provision of morning care to the identified resident on the resident's care unit, observed the lunch time meal service of September 3 2010 on the resident's care unit, examined the identified resident's room and observed the identified resident's early afternoon care on September 3, 2010.

The following Inspection Protocols were during this inspection:

- Falls Prevention
- Personal Support Services
- Skin and Wound
- Ad Hoc Notes

3 Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007 S.O. 2007, c.8, s. 6
(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

c) clear direction to staff and others who provide direct care to the resident.

(9) The licensee shall ensure that the following are documented:

1. the provision of the care set out in the plan of care.
2. the outcomes of the care set out in the plan of care.
3. the effectiveness of the plan of care.

(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

b) the resident's care needs change or care set out in the plan is no longer necessary; or
c) care set out in the plan has not been effective.

Findings:

1. **The resident's care plan indicates that the resident has a wheelchair lap belt restraint that is to be applied when the resident is up in the wheelchair, is to be removed and the resident is to be readjusted / repositioned every 1 hour. Health care aid daily care directives do not identify the need to apply, remove and readjust / reposition the resident every 1 hour.**
2. **The resident's plan of care indicates that staff are to provide constant supervision and physical assistance for safety during toileting. The attending health care aid did not stay with the resident when she was seated on the toilet on February 25 2010. The resident fell and sustained an injury.**
3. **The resident's wheelchair lap belt, seat cushion and arm rest sides were soiled with food debris and liquid spillage on September 3, 2010. The resident's plan of care does not identify the need to regularly clean the resident's wheelchair.**

Inspector ID #:	# 117

WN #2: The Licensee has failed to comply with the O.Reg. 79/10, section 110 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

(5) the person who applied the device and the time of application.
(6) all assessment, reassessment and monitoring, including the resident's response.
(7) every release of the device and all repositioning
(8) The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Findings:

1. **There is no documentation that the resident's lap belt was applied, removed and readjusted / repositioned as well as the resident's response every 1 hour, as per the resident's plan of care, from November 2009 to September 2010.**

Inspector ID #:	# 117

WN #3: The Licensee has failed to comply with the O.Reg. 79/10, Section 37(1)(b) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,

b) cleaned as required.

Findings:

1. **The resident's wheelchair lap belt, seat cushion and arm rest sides were soiled with food debris and liquid spillage on September 3, 2010.**

Inspector ID #:	# 117

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). October 13, 2010