

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act. 2007 Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division

Performance Improvement and Compliance Branch Division de la responsabilisation et de la

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Date(s) of inspection/Date(s) de l'inspection

Inspection No/ No de l'inspection

Type of Inspection/Genre d'inspection

Jul 7, 25, 2011

2011 044161 0009

Critical Incident

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY

2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR 1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the licensee's Executive Director and the Director of Care.

During the course of the inspection, the inspector(s) reviewed the health record of an identified resident and the licensee's investigation notes related to a Critical Incident which occurred in August 2010 and a Critical Incident which occurred in March 2011.

The following Inspection Protocols were used in part or in whole during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

Definitions Définitions WN - Written Notification VPC - Voluntary Plan of Correction DR - Director Referral CO - Compliance Order WAO - Work and Activity Order DR - Non-RESPECT DES EXIGENCES WN - Avis écrit VPC - Plan de redressement volontaire DR - Aiguillage au directeur CO - Ordre de conformité WAO - Ordres : travaux et activités



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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. 6. Plan of care Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits sayants:

- 1. The licensee failed to comply with s. 6 (7) to ensure that staff provide the care as set out in the plan.
- 2. An identified resident's plan of care in August 2010 indicates that she transfers with two persons using a tempo lift.
- 4. According to a Critical Incident Report submitted by the licensee to the Director, in August 2010, one staff member transferred the identified resident from her chair to her bed.
- 5. An identified resident's plan of care plan of care in March 2011 indicates that she transfers with two persons using a tempo lift.
- 6. On March 6, 2011 an identified resident was observed by two Personal Support Workers (PSW's) to be sliding down in her chair. During the interviews between the licensee's Director of Care and the PSW's, the PSW's indicated that they did not use a tempo lift to transfer the identified to a safe position in her chair.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 3rd day of August, 2011

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

Adulle Miller