



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

**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  
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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|--------------------------------|--|
| Dec 30, 2013                                   | 2013_272533_0003                              | O-001162-<br>13                | Complaint  |

**Licensee/Titulaire de permis**

peopleCare Not-For-Profit Inc  
2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR  
1150 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

SUSAN MCGLADE (533)

**Inspection Summary/Résumé de l'inspection**

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): December 11, 12 and 13, 2013**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care,(DOC) Registered Practical Nurse (RPN), Personal Support Workers (PSW) Residents #1, #2 and #4.**

**During the course of the inspection, the inspector(s) toured the unit, reviewed the plan of care, progress notes and the residents' bath schedule.**

**The following Inspection Protocols were used during this inspection:  
Personal Support Services**



Findings of Non-Compliance were found during this inspection.

| <b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>   |  |
|---|--|
| <p>Legend</p> <p>WN – Written Notification<br/> VPC – Voluntary Plan of Correction<br/> DR – Director Referral<br/> CO – Compliance Order<br/> WAO – Work and Activity Order</p>  | <p>Legendé</p> <p>WN – Avis écrit<br/> VPC – Plan de redressement volontaire<br/> DR – Aiguillage au directeur<br/> CO – Ordre de conformité<br/> WAO – Ordres : travaux et activités</p>  |
| <p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |



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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing  
Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with The Long-Term Care Homes Act, 2007 S.O. 2007, CHAPTER 8, r.33.(1), in that Residents #1 and #4 did not receive their scheduled baths on several occasions.

Resident #1 was interviewed by Inspector #533 and reported that he/she had missed two baths during the period of November 25-29,2013. Resident #1's plan of care was reviewed as well as the bath schedule which identifies Mondays and Thursdays as his/her preferred bath days. Staff member #S100 was interviewed and indicated that there were not enough staff to give Resident #1 his/her baths that week. Resident #1 clearly states that when Modified staff are on duty, they are unable to assist with showers, and this took place over several weeks. Resident #1 expressed that he/she is upset with not receiving his/her bath.

Resident #4 was interviewed by inspector #533 and reported that he/she had missed one bath during the period of November 25-29,2013.The Inspector reviewed the plan of care and bath schedule which identifies Sunday and Wednesday evenings as preferred bath days. One bath was missed during this time.  
Resident #4 expressed disappointment at having missed his/her bath.

Progress notes were reviewed for Resident #1 and Resident #4 and there are no entries to indicate the reason why the baths were not given and Resident #1 reported there were no offers of an alternate bath time given to him/her. [s. 33. (1)]

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Issued on this 3rd day of January, 2014

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

*Susan McClade*