Ontario

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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 23, 2016;	2016_389601_0013 (A1)	012300-16	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

KARYN WOOD (601) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 6, 7, 8, 9, 13 and 14, 2016.

The following critical incidents were inspected:

Log #008264-16 (CI #2605-000008-16), log #012300-16 (CI #2605-000010-16), log #011596-16 (CI #2605-000009-16), and log # 005154-16 (CI#2605-000003-16) related to falls.

Log #013409-16 (CI #2605-000013-16) and log #007664-16 (CI #2605-000007-16) related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and Residents.

The inspectors also conducted a tour of one home area, observed staff to resident interaction, reviewed resident health care records, the licensee's documentation related to the investigation records, the critical incidents documentation, falls records, and applicable policies.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 saillants :

(A1)
1. The licensee has failed to ensure that resident #001's plan of care was based on

an assessment of the resident and the resident's needs and preferences.

Related to log #011596-16:

A critical incident (CIR) was received reporting that resident #001 was transferred to the
hospital for an incident that resulted in a significant change in the resident's health status.

Review of the CIR , clinical documentation and interviews with resident #001, RPN #104 and the Administrator indicated that resident #001 had an unwitnessed fall. The resident reported the fall to the registered staff, who assessed the resident and found a minor injury. Pain assessment indicated the resident was experiencing pain after the fall.

Clinical documentation indicated that during the post fall period, resident #001, had requested to be sent to the hospital for further assessment twice.

From the date of the fall until resident #001 was transferred to the hospital for unrelated circumstances approximately twelve days after the fall, resident #001 continued to complain of discomfort and difficulty with mobility. Resident #001 was transferred to the hospital and received further treatment related to the initial fall. [s. 6. (2)]

2. The licensee failed to ensure that resident #007's care set out in the plan of care related to transferring was provided to resident #007 as specified in the plan.

Related to log #013409-16:

PSW #103 reported to the nurse that PSW #100 had transferred resident #007 without assistance.

Review of resident #007's plan of care in place at the time of the incident identified that resident #007 required two staff for all transfers.

According to the Administrator, during the homes investigation regarding the allegations brought forward by the PSW #103, resident #007 and PSW #100 both indicated that PSW #100 did transfer the resident without assistance as specified in resident #007's plan of care. [s. 6. (7)]

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 to ensure that resident #001's plan of care is based on an assessment of the resident and the resident's needs and preferences are met. A written plan of correction for achieving compliance to ensure that resident #007's care set out in the plan of care related to transferring is provided to resident #007 as specified in the plan, to be implemented voluntarily.

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.