Ontario

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 prévue sous *la Loi de 2007 sur 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2019	2019_694166_0018	005775-19, 007476-19, 008856-19, 009672-19, 011526-19, 011860-19, 011861-19, 012299-19, 012300-19, 012348-19, 016577-19	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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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): August 20, 21, 22, 23, 26, 27,28, 29, 2019

The following were inspected concurrently during this inspection:
Log # 005775-19, Log # 008856-19, Log # 009672-19, and Log # 011526-19 related to allegations of resident to resident abuse,
Follow up to Compliance Order #001, log # 012299-19, related to responsive behaviours,
Follow up to Compliance Order #002, log # 012300-19, related to immediate reporting to the Director,
Follow up to Compliance Order #001, log # 011860-19 and follow up to Compliance Order #002, log # 011861-19, related to medications,
Log # 016577-19, related to an unexpected death,
Log # 007476-19 and Log # 012348-19, related to falls.

Inspector Jack Shi (760) attended this inspection during orientation.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper (HSK), Activity Aide (AA), Restorative Aide (RA), Physiotherapy Assistant (PTA) and Behaviourial Support Ontario (BSO).

During the course of this inspection, the Inspectors, observed resident to resident interactions and staff to resident interactions during the provision of care. The Inspectors reviewed the clinical health records of identified residents, reviewed the licensee's investigation documentation related to abuse and medication incidents, mandatory education records, BSO documentation, Professional Advisory Committee (PAC) meeting records, policies related to medication and the safe use of bathing chairs.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 135. (1)	CO #001	2019_643111_0008	166
O.Reg 79/10 s. 135. (2)	CO #002	2019_643111_0008	166
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2019_643111_0006	194
O.Reg 79/10 s. 54.	CO #001	2019_643111_0006	194

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee failed to ensure that the care set out in the plan of care for resident #003 related to identified responsive behaviour was provided to the resident as specified in the

plan.

Related to log #011526-19:

A Critical Incident Report (CIR) was submitted to the Director reporting an incident of resident to resident abuse. Review of the CIR documentation by Inspector #194, indicated that on a specified date, resident #003, was seated waiting to be transferred back to their room. Resident #004, walked to resident #003 and at the time of the incident, PSW #128, observed resident #003 displaying an identified responsive behaviour towards resident #004. Review of the licensee's investigation and interview with the Manager indicated the nurse reported the incident immediately.

Review of resident #003's plan of care by Inspector #194, indicated, that the resident had a recent history of displaying the identified responsive behaviour.

Review of resident #004's plan of care by Inspector #194, indicated, that resident #004 had a history of seeking out other residents.

Review of the plan of care for resident #003 related to the identified responsive behaviour indicated that resident #003 was not be left unattended.

During an interview with Inspector #194, RPN #127, indicated, they were at the nursing station and at that time and PSW staff were escorting residents . Resident #004 and resident #003 were seated in an area where both residents were able to be observed. RPN #127 indicated that resident #003 required close monitoring. RPN #127 indicated, that they did not witness the incident, as they were distracted at the nursing station at the time.

During an interview with Inspector #194, PSW #128 indicated that they were aware resident #003 had a history of the specified responsive behaviour and quickened their pace to intervene between resident #003 and resident #004. PSW #128 indicated, before they were able to reach the residents, resident #004, who was ambulatory, had leaned over to speak to resident #003. Resident #003 then reached out and directed the identified responsive behaviour towards resident #004.

The licensee failed to ensure that the interventions set out in the plan of care, related to the monitoring/management of the specified responsive behaviour for resident #003 was provided as directed in the plan. On a specified date, resident #003 was left unattended

near resident #004, which resulted in an incident of resident to resident responsive behaviour, by resident #003 directed towards resident #004. [s. 6. (7)] (194)

During this inspection, Inspector #194, reviewed clinical health records for resident #004, involved in the previous incident, related to responsive behaviours. Review of documentation by Inspector #194, indicated, that on a specified date, resident #004 approached and tried to speak to resident #024. Resident #024 asked resident #004 to go away, then resident #004 lightly smacked resident #024 on the arm. Resident #024 then slapped resident #004 across the face, causing resident #004 to cry.

Review of resident #004's plan of care indicated that the resident had a history of seeking out other residents and was to be monitored and kept away from other residents who display a specified responsive behaviour.

Review of resident #024's plan of care indicated that resident #024 had a history of displaying a specified responsive behaviour directed towards co-residents.

During an interview with Inspector #194, related to the responsive behaviours of resident #004 and resident #024, RPN #103, confirmed that both residents displayed responsive behaviours. RPN #103 indicated, that resident #004 was to be monitored and that resident #024 could display this behaviour towards co-residents and had a previous history of that specific behaviour towards resident #004

During interview with Inspector #194, related to this incident, the Administrator confirmed that resident #024 had a history of a specified responsive behaviour directed towards co-residents and that resident #004 was to be kept away from residents who could display this behaviour.

The licensee failed to ensure that the interventions identified in resident #004's plan of care, related to the risk of physical harm from co-residents was provided to the resident. On a specified date, resident #024, who had a history of a specified responsive was near resident #004. The encounter between resident #024 and resident #004 resulted in an incident of resident to resident abuse which caused an injury to resident #004. [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 the care set out in the plan of care is provided to resident #003 and #004 as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that safe positioning devices or techniques was used when assisting residents.

Related to log #007476-19:

A Critical Incident Report (CIR) was submitted to the Director reporting an improper /incompetent treatment of a resident that resulted in harm or risk of harm to a resident, after resident #019 fell from an assisted bathing device and sustained an injury.

The RN supervisor assessed the resident and found minor injuries. The Range of Motion (ROM) assessment indicated no further injuries were noted at the time of the fall. Resident #019 was then transferred into bed where a further assessment was completed.

During an interview with Inspector #166, the Administrator confirmed that the assisted bathing device safety belt was not in place or utilized when resident #019 fell.

Review of the licensee's internal investigation indicated that PSW #121 did not apply the safety belt as required by the manufacturer's procedure and the licensee's safety policy for safe use of the assisted bathing device

The licensee has failed to ensure that a safe positioning device was used when resident #019 was transferred into the assisted bathing device then subsequently fell causing injury to the resident. [s. 36.]

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 safe positioning devices or techniques are used when assisting residents, to be implemented voluntarily.

Issued on this 20th day of September, 2019

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

Original report signed by the inspector.