Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 24, 2023	
Inspection Number: 2023-1116-0002	
Inspection Type: Critical Incident System	
Licensee: Glen Hill Terrace Christian Homes Inc.	
Long Term Care Home and City: Glen Hill Strathaven, Bowmanville	
Lead Inspector Holly Wilson (741755)	**Inspector Digital Signature** Holly N Wilson Digitally signed by Holly N Wilson Date: 2023.03.24 11:05:21 -04'00'
Additional Inspector(s) Rexel Cacayurin (741749) Sarah Gillis (623)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 27, 2023- March 3, 2023

The following Critical Incidents (CIR) were inspected:

- Intake: #00006771 – related to staff to resident abuse.
- Intake: #00019469 – related to improper care of a resident.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Safe and Secure Home

Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 138 (1) (a) (ii)

Noncompliance with O.Reg. s.138 (1)(a)(ii)

The licensee has failed to ensure the medication and treatment cart was locked at all times.

While conducting an IPAC tour, it was observed that a treatment cart and medication cart were unlocked and left unattended by registered staff.

The Director of Care (DOC) confirmed the expectation of the home is to keep the medication cart and treatment cart locked at all times.

Failure to secure drugs in the locked medication cart presented minimal risk of residents access to medications. There were no residents within proximity to the carts at the time of observation. RPN #103 and RPN #105 locked the medication and treatment carts once it was brought to their attention.

Subsequent observations throughout the remainder of the inspection revealed no concerns, with carts being closed and locked.

Sources:

Observation, Interview with DOC, Interview with Staff #103 and Staff #105

[741749]

Date Remedy Implemented: February 27, 2023

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 142 (1)

The licensee failed to ensure, with respect to residents, the administration, possession, storage, and disposal of recreational cannabis is in accordance with all applicable laws, including, without being limited to, the *Cannabis Act* (Canada) and the *Cannabis Regulations* (Canada).

Rationale and Summary

The Cannabis Policy indicates the following:

- resident must be of sound mind and capable of making decisions. Cognitive Performance Score CPS of 0-2/6
- must be able to manage their access to the smoking area and the smoking process by themselves
- under Bill 36, smoking or vaping is not permitted in the enclosed public spaces or enclosed workplaces.
- smoking or vaping of cannabis is not permitted in the Long-Term Care Home or residences.

During the inspection, a resident's room had an odor of cannabis inside the room and in the hallway. The resident was observed at their bedside, with open cannabis on their bed.

On another occasion during the inspection, a resident was inside their room, at their dresser, with a locked box. The resident willingly showed the inspector the contents of the locked box, including a clear plastic bag of cannabis.

The resident has a history of smoking recreational cannabis and cigarettes. Review of progress notes for the resident indicate that the resident had been found smoking recreational cannabis and cigarettes in the room, and washroom on several occasions. The progress notes indicate a co-resident had complained of the strong odor.

PSW #111 indicated that the resident was found smoking cannabis or cigarettes in the home on multiple occasions. The DOC and ADOC confirmed that no resident is allowed to smoke in the home, that the resident has been found smoking cannabis and cigarettes in their room, and washroom.

When the home failed to ensure that the resident was smoking safely as per the homes' policy, this placed other residents at a safety risk, risk of fire, and cannabis inhalation.

Sources:

Observations, Cannabis Policy, resident's plan of care, progress notes, interviews of Staff #111, ADOC, DOC.

[741755]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care for a resident, collaborate with each other in the development and implementation of the plan of care related to the use of a device for feeding.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care which indicated that a resident was transferred to the hospital concerning their device used for delivery of nutrition. RN #109 contacted the hospital to clarify that the new device was to be used for the delivery of nutrition and medication administration. The following day, the physician was notified, and the resident was transferred back to hospital where they remained for four days awaiting a replacement device.

RN #109 and RPN #110 each confirm they did not contact the Physician. The DOC confirmed they called the physician regarding the improper use of the new device, and they had the resident sent to the hospital immediately.

Failing to collaborate with the physician when the resident returned from the hospital with a new device used for the delivery of nutrition and medications, resulted in the resident receiving improper care and risk of dehydration.

Sources:

CIR, Resident's progress notes, interviews with Staff #109, Staff #110, and DOC.

[741755]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section 5.4 (g)

1) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), Additional Requirement 5.4 (g) directs the licensee to ensure that the policies and procedures for the IPAC program also address IPAC related practices for aerosol generating medical procedures (AGMPs).

Rationale and Summary

The Continuous Positive Airway Pressure (CPAP) Policy indicates:

- Staff and visitors must wear a mask for their protection when they are providing and direct care or contact with the resident while the CPAP machine is on.
- Initiate droplet contact precautions, if applicable, for potential of body fluid contact.

During the inspection, it was observed that a resident had a Continuous Positive Airway Pressure (CPAP) device, which is considered an AGMP, that may require additional contact and droplet precautions. The IPAC Lead, and the DOC were not aware of the additional requirements for signage to be posted on the door and PPE available for the AGMP, as was identified in the homes 'policy.

Public Health (PH) #112 confirmed that CPAP is an AGMP, and the precautions are droplet and contact if the resident is not a suspect/confirmed COVID-19 case. Signage should be posted at the door of the room to identify the AGMP and required PPE should be available at the entrance to the resident's room.

Failing to follow the homes' policies that address IPAC related practices for AGMPs, posed a risk to staff and residents from possible transmission of infections.

Sources:

CPAP Policy, Observations of a resident's room, plan of care for the resident, interview with IPAC Lead, DOC, and PH #112

[741755]

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section 10.2

2) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the 'Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022' (IPAC Standard), section 10.2 indicated the hand hygiene program shall be multifaceted and multidisciplinary. The licensee shall ensure that the program includes, at minimum, training and education, hand hygiene audits, a hand care program, and hand hygiene and hand care support for residents

Rationale and Summary

During the inspection, it was observed on two separate occasions, that residents did not receive assistance with completing hand hygiene before meal service.

On one occasion, it was observed that RN #113 was assisting three residents with cutting their food, feeding, and assisted transportation of residents to their respective table without hand hygiene. RN #113 indicated hand hygiene should be completed in between assisting residents but “sometimes it is busy, and they don’t get a chance”.

An interview with the IPAC Lead and DOC, indicated the expectation is that staff perform hand hygiene before and after resident contact and hand hygiene should have been offered to residents before their meal service.

Failure to perform hand hygiene before and after contact with residents, placed residents at risk of harm from the possible transmission of infectious agents. Failure to prompt and support residents to complete hand hygiene places staff and residents at risk for transmission of infectious agents.

Sources:

Observations of hand hygiene support for residents Interviews with IPAC Lead, DOC, and staff #113.

[741749] [741755]

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section 9.1 (e)

3) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the Infection Prevention and Control program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022" (IPAC Standard) 9.1. At minimum, Additional Precautions (e) shall include point-of-care signage indicating that enhanced IPAC control measures were in place as required.

Rationale and Summary

During the inspection, it was observed that point-of-care signage indicating that enhanced IPAC control measures were required, was missing from a resident's room. The sign indicated that the resident required Contact Droplet Precautions despite the resident not requiring any additional precautions. The co- resident was identified as requiring contact precautions as indicated in the plan of care and confirmed by RN# 104. There was no signage at the door to identify the additional contact precautions and there was no personal protective equipment (PPE) cart available outside the door.

Interview with IPAC Lead, DOC, and RN #104 confirmed they were not aware that the signage at point of care was incorrect, as there should have been signage on the doors of room. RN #104 replaced the correct signage for the correct resident and then placed the appropriate PPE cart at the door of the room.

Failure to ensure point-of-care signage indicating that enhanced IPAC control measures were required, placed residents and staff at risk from possible transmission of infectious agents.

Sources:

Observations and interview with Staff #104.

[741755]

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section 6.1

4) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, April 2022" (IPAC Standard) 6.1. The licensee shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and

stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

Rationale and Summary

During the inspection it was observed that several residents' rooms had point of contact signage on the door indicating contact precautions. Several of the PPE carts, outside the entrance of the resident's room did not contain the required PPE that was identified as necessary.

During separate interviews, the IPAC Lead, ESM, DOC, and Public Health #112 all indicate that PPE should be available to all staff at Point of Contact when identified as requiring additional precautions.

Failing to have the appropriate PPE available and accessible to staff increases the risk of transmission of infectious agents between residents and staff.

Sources:

Observations, interview with IPAC Lead, ESM, DOC, and PH #112.

[741755]

Non-compliance with: O.Reg. 246/22, s. 102 (2) (b). Infection prevention and Control (IPAC) Standard Section 10.1

5) The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control was complied with.

The licensee is required to ensure that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under s. 102(2) of the Regulation, which includes, at a minimum, access to hand hygiene agents at point-of-care (para 11 of s. 102(7) of the Regulation). Additional Requirements under the standard: 10.1 The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary

During the inspection, it was observed at the front entrance to the home, that the stationary ABHR unit contained Soft Care Instant Foam Hand Sanitizer that was expired. Other portable bottles of ABHR were

also expired and found at the front entrance and screening table. Throughout the home, Soft Care Instant Foam Hand Sanitizer was observed in many wall dispensers and had also expired.

When IPAC Lead and ESM became aware of the expiry dates of the ABHR, they removed some expired product and replaced with the remainder of the available stock on hand. ESM confirmed that all the available non- expired ABHR was put into circulation and an order was placed for additional hand sanitizer to arrive to the home over the next four days.

An interview with ESM, identified their understanding was that expired hand sanitizer could be used for 1080 days/ 36 months after the expiry date on the product. Upon consultation with the company which manufactures the hand sanitizer, it was confirmed via email that "the shelf life on this product is 36 months 1080 days. We do not recommend using this product after the expiry date as we cannot guarantee effectiveness after that time. There are no extensions on these products".

When the home failed to monitor the ABHR for expiration dates, this placed the residents and staff at risk of transmission of infectious agents.

Sources:

Observations, interviews with ESM, correspondence from the ABHR manufacturer.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 55 (2) (b) (i)

O. Reg 246/22 s. 55 (2) (b) (i), The Licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff using clinically appropriate assessment instrument that is specially designed for skin and wound assessment.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care which indicated that a resident had an alteration in skin integrity from an incident that occurred.

During an interview with the DOC, they indicated the registered staff and wound care nurse are expected to use the home's skin and wound assessment tool when assessing resident's altered skin integrity.

During an interview with the Wound Care RN #114, the home has a designated skin and wound assessment tool that is to be used when assessing and monitoring residents' altered skin integrity. RN #114 confirmed the skin and wound assessment tool was not used for the identified resident.

Failure to ensure the use of clinically appropriate assessment instrument to assess and document the resident's altered skin integrity may lead to a delay in implementing interventions and treatments which could compromised wound healing.

Sources:

CIR, Interview with Wound Care RN #114, and DOC, Resident #001's progress notes, Assessment.

[741749]

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and

(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal

within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca