Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: June 21, 2023	
Inspection Number: 2023-1116-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Glen Hill Terrace Christian Homes Inc.	
Long Term Care Home and City: Glen Hill Strathaven, Bowmanville	
Lead Inspector Moses Neelam (762)	**Inspector Digital Signature**
Additional Inspector(s) Tiffany Forde (741746)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6, 8 - 9, 12 -14, 16, and offsite on June 7, 2023

The following intake(s) were inspected:

- Intakes related to alleged staff to resident abuse
- Intakes related to multiple care issues
- Intake related to falls
- Multiple intakes were completed in this inspection related to falls.

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Palliative Care

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the plan of care for resident #003 was followed.

Rationale and Summary

A complaint was made to the Director with regards to multiple areas of concern. A review of the resident #003's care records indicated that the resident was to receive a specific type of intervention. In the progress notes, it was documented that the resident received an alternate intervention which they had taken part in, without harm. In separate interviews an RPN and the Dietary Manager (DM) indicated that this was unsafe for the resident. As such the resident was at risk due to the wrong intervention being provided.

Sources: Progress notes; Care Plan; Interviews with RPN and Dietary Manager[762]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure the homes written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The Long-Term Care Home (LTCH) defines physical abuse in accordance with O.Reg., 246/22, and is as follows:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

Physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Rationale and Summary

A complaint was made to the Director regarding an incident that occurred with resident #001. A review of the resident's care records did not contain any indication of the alleged incident; however, the LTCH was able to provide the investigation notes for the incident. The investigation notes indicated that there was an altercation between two staff members, in separate interviews, a PSW and RN, indicated that the resident's was affected due to this incident. In an interview on two separate occasions, the resident recalled the incident, described the persons involved, and described the effect it had on the resident. A assessment was conducted by the Nurse Practitioner (NP), a few days after the incident, however, the assessment did not specify if the cause of the negative effect on the resident was due to the incident.

In an interview, Assistant Director of care (ADOC) indicated that the LTCH policy in this situation would require for an assessment to be documented in the care records and that the LTCH's policy requires the residents to be protected from abuse. As such there was a risk to the resident not receiving care for the correct reasons, because the policy was not followed.

Sources: Abuse policy; Progress notes; Interviews with Resident, NP, ADOC and RNs [762]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that resident #003 received the correct intervention as required by the plan of care.
Rationale and Summary

A complaint was made to the Director with regards to multiple areas of concern. A review of the resident #003's care records indicated the resident required an intervention with a certain number of staff and that this intervention was not followed. In an interview, PSW #100 indicated that they conducted the intervention alone, in the presence of the resident's family member. The Physiotherapist (PT) indicated that this practice would be considered unsafe. As a result, the resident was at risk for injury due to the unsafe intervention.

Sources: Progress notes; Care Plan; Assessment; Interviews with PSW #100 and Physiotherapist