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: February 13, 2024
Inspection Number: 2024-1116-0001
Inspection Type: Complaint Critical Incident
Licensee: Glen Hill Terrace Christian Homes Inc.
Long Term Care Home and City: Glen Hill Strathaven, Bowmanville

Lead Inspector	**Inspector Digital Signature**
Rita Lajoie (741754)	Rita Lajoie Digitally signed by Rita Lajoie Date: 2024.02.16 10:47:31 -05'00'

Additional Inspector(s)
Tiffany Forde (741746)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23 - 26, 29, 30, 2024

The following complaints and critical incidents were inspected:

- Intake: #00088968 - Resident to resident responsive behaviours.
- Intake: #00089216 - Call from resident anonymous concerns cold food, shortage of PSW.
- Intake: #00102842 - Fall of resident resulting in fracture.

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

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from physical abuse by a co-resident.

Under FLTCA, 2021, Ontario Regulation 246/22, section 2 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Summary Review
A critical incident report (CIR) was submitted to the Director, regarding resident-to-

resident physical abuse. In an interview a PSW indicated that they responded to the call bell in a resident room. When they entered the room, they witnessed a resident in an altercation with a co-resident. The PSW witnessed the resident punching the co-resident causing redness to the skin.

The PSW intervened and separated the two residents. An RPN came to assist, conducted a head-to toe assessment and noted redness to an area of the resident's skin.

Failure to ensure that a resident was protected from abuse by a co-resident resulted in risk of emotional harm to the resident.

Sources: CIR , LTC home's investigation notes, interviews with PSW, RPN. [741746]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that a resident was provided with strategies to reduce or mitigate falls, including the monitoring of falls.

Rationale and Summary

A critical incident report (CIR) was received by the Director for an incident that caused injury to a resident for which they were taken to hospital.

The CIR indicated that a resident was found by a staff member sliding out of bed. The resident sustained an injury for which they were transported to hospital. Assessment was completed and a fracture was confirmed.

Observations were made of the resident on three separate dates. The resident was observed resting in bed with the bed elevated to the 'high' position. During one of the observations an RPN confirmed that the instructions posted on the wall above the bed indicated that the bed should always be in the lowest position and that at the time of the observation the bed was not in the lowest position.

Signage was observed posted on the wall behind the bed detailing 'Fall Prevention Interventions' for the resident indicating the 'HI/LOW Bed remains at lowest position."

Review of the resident's clinical records indicated staff were to 'Place bed in lowest position, use high/low bed to prevent falls from bed.'

Review of the resident progress notes from the time of the incident demonstrated six separate observations documented by care staff that the resident's bed was not placed in the lowest position.

Failure to ensure that the resident's bed remains in the lowest position at all times puts the resident at ongoing risk of injury if they attempt to exit the bed without assistance.

Sources: CI# , review of progress notes, Kardex, written plan of care, interviews with DOC, ADOC, and RPN, observations of resident, signage above bed [741754]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Specifically, staff did not comply with the LTC homes' "Responsive Behavior Policy", which was included in the licensee's Responsive Behaviours Program.

Rationale and Summary:
A critical incident report (CIR) was submitted to the Director regarding a witnessed incident of resident to resident physical abuse. A resident was observed to be physically abused by a co-resident. The Behavioural Supports Ontario (BSO) lead indicated that a monitoring flowsheet was not initiated after a resident demonstrated a responsive behaviour. The BSO lead acknowledged the monitoring system flowsheet should have been initiated in accordance with the homes' Responsive Behaviour policy. The Director of Care (DOC) confirmed the monitoring system flowsheet should have been initiated immediately following the incident.

Failure to complete the monitoring system after the resident demonstrated

responsive behaviour increased the risk of harm to others .

Sources: Interviews with BSO lead, DOC, Responsive Behavior Policy-VII-F-30.00 revised , physician orders.
[741746]

WRITTEN NOTIFICATION: Police notification

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure the appropriate police service was immediately notified of an alleged incident of resident abuse.

Summary Review
A critical incident report (CIR) was submitted to the Director for a witnessed resident-to-resident physical abuse. In an interview a PSW indicated that they responded to the call bell in a resident's room. When they entered the room they witnessed a resident in an altercation with a co-resident. The PSW witnessed a resident punching a co-resident causing redness to the skin.

Review of the critical incident report indicated police were not notified of the alleged abuse with injury.

During an interview the DOC acknowledged that the police were not called.

Failure to inform police of an alleged abuse incident, with injury, prevents police from immediately investigating, and may place the resident at risk of harm.

Sources: CIR, interview with DOC and PSW#112
[741746]

COMPLIANCE ORDER CO #001 Dining and snack service

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.Food Services Manager (FSM) to provide in person training for all Dietary Aids regarding record keeping and Point of Service temperature recording, especially in regard to corrective measures. Have all staff sign off on the training records and make these records available upon inspector request.

2.FSM to conduct daily audits of temperature logs for all three meals for two weeks. The records should show corrective actions taken when temperatures are not within a safe range. Then FSM will then conduct weekly audits for three weeks. The

records will be kept and made available to the inspector to review upon request.

Grounds
The licensee has failed to ensure that the temperature of food and fluids served to residents was maintained at a safe and palatable temperature.

Rationale and Summary
A complaint was received by the Director in regard to food temperatures being too cold at breakfast meals and no hot meals. During an interview a resident indicated that the eggs were too cold and that the bacon served was so cold dried oil could be seen on it. In an interview another resident indicated that "the vegetables are always cold, no sense talking about it. It doesn't taste good when they're cold and it takes the flavor out". The resident also indicated that they stopped eating the vegetables because they were always cold. In an interview a Dietary Aide explained food temperatures should be taken prior to serving the meals to residents and should be recorded daily in the point of service temperature logs.

The Point of Service (POS) in the Main west dining room, food temperatures logs for the month of January were reviewed. There were many dates of incomplete or missing data and temperatures that did not meet the requirements for palatable food. Cold food temperatures were recorded with no corrective actions noted for correcting temperatures outside of safe ranges.

Another review of temperature records revealed that the home served baked ham and battered fish for dinner with record temperatures for each hot item recorded as 49 degrees Celsius (120.2F) and 40 degrees Celsius (104F). The vegetable number two served at this meal was recorded at 51 degrees Celsius (123.8F). Minced entre number one was 40 degrees Celsius (104F). Hot food is required to be 60 (140F) degrees Celsius or greater when being served. There were no temperatures

recorded for beverages and incomplete records for puree entree number one. The LTC home also failed to adopt one clear method of recording temperatures specifically to use either Celsius or Fahrenheit when recording temperatures.

Observations were completed during a lunch meal service. In the main kitchen production temperatures of food were taken by two Dietary staff. The FSM was present. Puree Salad (green) was 54 degrees Fahrenheit and Minced salad was 47 degrees Fahrenheit. The Dietary staff were asked what corrective actions were to be taken and they were unable to provide responses as per the home's policy. Ultimately, these food Items were not served during lunch food service as the temperature requirements could not be met. They were replaced with another item.

Failure to ensure that the temperatures of food and fluids served to residents are safe and palatable can cause food-born illnesses.

Sources: Interviews with residents, dietary aides, observations, review of temperature records.
[741746]

This order must be complied with by March 29, 2024

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.