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: August 14, 2024

Inspection Number: 2024-1116-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Glen Hill Terrace Christian Homes Inc.

Long Term Care Home and City: Glen Hill Strathaven, Bowmanville

Lead Inspector	**Inspector Digital Signature**
The Inspector	April W Chan Digitally signed by April W Chan Date: 2024.09.10 14:35:48 -04'00'

Additional Inspector(s)
The Inspector
The Inspector

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 16 - 19, 22 - 26, 29, 2024

The following intake(s) were inspected:
Intake: #00109073 - Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 5.
Intake: #00109583 - An incident which resulted in a resident being taken to hospital
Intake: #00111527 - Alleged staff to resident abuse
Intake: #00111649 - Alleged resident to resident abuse.
Intake: #00112631 - An outbreak of infectious disease

Intake: #00112878 - Complaint related to multiple care concerns and operation of the home.
Intake: #00113482 - An incident which placed a resident in risk of harm.
Intake: #00114370 - An incident which resulted in a resident being taken to hospital.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1116-0001 related to O. Reg. 246/22, s. 79 (1) 5. inspected by the Inspector.

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces in accordance with manufacturer's specifications.

Rationale and Summary:
In accordance with section 93. (2) (b) (iii) of the Regulation, the licensee shall have an organized program of housekeeping with procedures developed and implemented for disinfecting contact surfaces in accordance with manufacturer's specifications. Specifically, the licensee's policy on Chemical Disinfectant – Housekeeping indicated that testing the titration of disinfectant chemicals in the home occurred on a weekly basis.

A housekeeper indicated that the disinfectant testing was done daily and documented on a log form kept in the housekeeping storage room. However, the log form was not found by the housekeeper in the housekeeping storage room. Interview with another housekeeper indicated that disinfectant test was not performed because the testing strips supplied was indicated for use for the previous disinfectant product and not for the disinfectant product in use.

The Administrator acknowledged that housekeeping staff were not performing disinfectant testing when the home previously changed disinfectant products. The Administrator indicated that the product representative advised that disinfectant testing can be done weekly and that tests were to be supplied to the home.

On a later date, the Environmental Services Manager showed that the home was supplied with disinfectant indicator test strips and provided demonstration. They indicated that the product representative visited the home to provide training on the use of indicator test strips and tested all of the automatic dispensing units and found no concern. The Environmental Services Manager indicated that the home implemented procedures to perform daily disinfectant testing. Review of the licensee's policy on Chemical Disinfectant – Housekeeping indicated that it was updated to state that the dispensed disinfectant would be tested daily.

The failure to test disinfectants used for contact surfaces had posed a potential risk of ineffective environmental disinfection.

Sources: observation, licensee's policy on Chemical Disinfectant – Housekeeping, interviews with Administrator, Infection Prevention and Control (IPAC) Manager, Environment Service Manager, and staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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 program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, failed to ensure point of care signage was posted in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard). Specifically, Additional Requirement 9.1 Additional Precautions e), states that at a minimum Additional Precautions shall include Point-of-Care signage indicating that enhanced IPAC control measures are in place.

Rationale and Summary:
Through initial IPAC observation of the home, a number of shared bedrooms was observed with additional precautions signage posted outside of the room and did not specify which resident required enhanced IPAC control measures.

Interview with the Associate Director of Care (ADOC) indicated that the posted signage outside shared rooms should indicate the bed number and that the Registered Nurse (RN) supervisors were responsible to perform that task.

The additional precautions signages outside the room were corrected with specific

bed numbers to indicate the resident who required enhanced IPAC control measures on the same day that ADOC was notified by the Inspector.

Failure to ensure signage outside a shared room indicating that enhanced IPAC control measures were in place specific to the resident impact communication of these measures to staff, students and visitors.

Sources: observations, interview with ADOC and staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that a staff member participated in the implementation of the home's IPAC program.

Rationale and Summary:
During a tour of the home, a Personal Support Worker (PSW) was observed in the hallway of a resident home area while wearing gloves that were wet. The PSW acknowledged that they did not remove their gloves used for resident care and should have removed gloves upon exiting a resident room.

Interview with the ADOC indicated that as part of the home's IPAC practices, staff were expected to remove gloves and perform hand hygiene if they required to exit a resident's room.

Failure to remove personal protective equipment and perform hand hygiene increases risk of transmitting microorganisms in the home.

Sources: Observations, interviews with ADOC and staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents are recorded for a resident.

Rationale and Summary:
A resident was suspected to have an infection on a specific date. The resident received monitoring and symptoms indicating the presence of infection were recorded every shift starting that date. There was missing documentation regarding resident's symptoms of infection upon review of shift documentation.

A Registered Practical Nurse (RPN) indicated that they worked the specific shifts when missing documentation was noted by the Inspector. The RPN indicated that they were not aware of requirements of shift documentation for residents presenting with symptoms of infection.

The IPAC Manager indicated that staff were expected to document the signs and symptoms of infection every shift in the resident's clinical record.

Failure to record the resident's symptoms indicating the prescience of infection on every shift may impact health monitoring of the resident.

Sources: clinical records, and interview with IPAC Manager and staff.

WRITTEN NOTIFICATION: Medication management system

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123
Medication management system
s. 123.
(1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
(2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
(3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director.

The licensee has failed to ensure that the "Medication Administration" policy was complied with. The home specifically failed to ensure that registered staff initialed the Medication Administration Record (MAR). According to the policy registered staff were to document or utilize codes provided on the MAR, to indicate if a dose was omitted.

Rationale and Summary:
A Critical Incident Report (CIR) was submitted to the Director related to the use of specific medication for a resident.

The home's Medication Administration policy indicated that once a medication has been administered, staff were to document to indicate that medication was provided to the resident. The same policy also specified that if a dose were to be omitted, specific documentation on the MAR was required.

The resident was prescribed specific drug therapy and specific monitoring. The resident's MAR for a specific month indicated a number of missing documentation for the specified drug therapy and monitoring.

An interview with an RPN confirmed that once a medication is administered to a resident, the MAR should be signed and documented. A Clinical Pharmacist had clarified that if documentation was missing, this would indicate that either the medication was not administered to the resident or that staff had administered the medication and failed to document. An interview conducted with another RPN confirmed that missing documentation on home's paper MAR posed a risk to the resident. During an interview with Director of Care (DOC), they confirmed that

missing documentation did not follow the home's policy related to medication administration.

Due to registered staff failing to document in the MAR, the resident was at an increased risk of being involved in a medication incident.

Sources: CIR, MAR, Medication Administration policy, interviews with a Clinical Pharmacist, registered staff and the DOC.

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
a) The Administrator or manager delegate will conduct physical checks, at minimum, on a number of resident home areas and main dining room area to ensure that the home is a safe and secure environment for its residents. The physical checks will be done by an attempt to open the door of the main dining room and the door of the refrigerator-freezer if present to ensure it is secured. The frequency of the checks shall be at minimum, three times a week for a period of three weeks between 1300 and 1500 hours.

b) The Administrator or manager delegate will retain documentation of physical checks completed. The documentation shall include the date of the check, the area checked, the name of the person completing the check, any findings, any corrective actions taken, including the date of any corrective actions taken. Immediately provide the documentation when requested by the Inspector for review.

Grounds
The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Rationale and Summary:
During a tour of the home, the Inspectors noted that a fridge, with a freezer compartment, contained food items including chips, ice cream bars, drinks and sandwiches that was accessible to all residents in the lounge area.

On another day, the Inspectors noted that a key was left in the key cylinder of a door leading to the main dining room on the ground floor. The Inspectors were able to enter the main dining room and access the servery area which was unrestricted. Hot steam tables, kitchen knives and food items such as bread and cereal were observed in the servery area with no staff present.

The Administrator confirmed that the door to the main dining room should be locked when unattended and the key should not be left inside the door.

Failing to restrict access to food items in the main dining room and in a lounge area posed a choking and allergen safety risk to residents with dietary restrictions and texture modified diets.

Sources: Observations, and interviews with Administrator.

This order must be complied with by September 20, 2024

COMPLIANCE ORDER CO #002 Doors in a home

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

a) The Administrator or manager delegate will conduct physical checks, at minimum, on a number of resident home areas to ensure all doors that lead to non-residential areas are kept closed and locked when not supervised by staff. The physical checks will be done by an attempt to open the door. The frequency of the checks shall be at minimum, three times a week for a period of three weeks during day shift.

b) The Administrator or manager delegate will retain documentation of physical checks completed. The documentation shall include the date of the check, the name of the person completing the check, the area(s) checked, any findings, any corrective actions taken, including the date of any corrective actions taken. Immediately provide the documentation when requested by the Inspector for

review.

Grounds
The licensee has failed to ensure all doors leading to the non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary:
During a tour of the home, a linen chute door, a storage room door, and a lounge storage door was found to be closed over, unlocked, and not supervised by staff. The linen chute room had access to an unsecured, top-hinged linen chute that led to the lower level. Materials kept inside the storage rooms included sandwiches, pizza, salad, and drinks.

On another date, a resident was observed inside a storage room, eating dry cereal from the dietary trolley and at the time was not supervised by staff.

Interview with the Administrator and a Registered Nurse indicated that the linen chute door and storage room doors should always be closed and locked when not supervised by staff.

Failure to ensure doors leading to non-residential areas were kept closed and locked places residents at risk.

Sources: observation and interviews with Administrator and other staff.

This order must be complied with by September 20, 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

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:

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

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.