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: December 2, 2024

Inspection Number: 2024-1116-0004

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Glen Hill Terrace Christian Homes Inc.

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 12 - 21, 2024 with November 15 as an off-site inspection day.

The following intake(s) were inspected:

- Intake: #00120182 - 2605-000027-24 - Fall of resident with injury.
- Intake: #00120675 - 2605-000028-24 - Fall of resident with injury
- Intake: #00120855 -Complainant regarding fall of a resident with injury.
- Intake: #00120943-2605-000030-24 - Resident to resident abuse.
- Intake: #00122186 - 2605-000032-24 - IPAC related to finalized Covid outbreak
- Intake: #00123217 - Complainant related to supplies and staffing.
- Intake: #00123333 - 2605-000034-24 -Falls prevention and management
- Intake: #00124077 - Follow-up #01 - CO #001 / 2024-1116-0003, FLTCA, 2021 - s. 5, Home to be safe, secure environment, CDD September 27, 2024

- Intake: #00124078 - Follow-up #01 - CO #002 / 2024-1116-0003, FLTCA, 2021 - s. 5, Doors in a home, CDD September 27, 2024.
- Intake: #00126196 - 2605-000036-24 - Fall of resident with injury.
- Intake: #00126680 - 2605-000038-24 - Fall of resident with injury.
- Intake: #00127927 - 2605-000039-24 - Fall of resident with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1116-0003 related to FLTCA, 2021, s. 5
Order #002 from Inspection #2024-1116-0003 related to O. Reg. 246/22, s. 12 (1) 3.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Incomplete documentation of care set out in care plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure the provision of the care set out in the plan of care for resident #001 was documented.

Rationale and Summary
A complaint was received by the Director about the fall, management, and health outcome of Resident #001.

The PSWs were required to document the care provided to the resident on every shift using POC. This included documenting every two hours (Q2hrs) repositioning, and bed mobility.

Resident #001's PCC documentation was incomplete for turning and repositioning.

Staff #107 confirmed all staff were to document the provision of care on each shift in POC at the time the task was completed or a time after the task was completed, not at the beginning of the shift in anticipation of completion. They also confirmed missing documentation of turning and repositioning of resident #001.

Furthermore, PSWs documented observing and informing registered staff about the changes in resident #001's coccyx. However, there is no documentation from registered staff acknowledging the changes noted in resident #001's coccyx, or the interventions/treatment carried out from when the coccyx progressed from intact on readmission to unstageable.

Staff #116 confirmed there is no documentation in PCC on the progression of the coccyx wound from intact on readmission to unstageable in August when they were made aware by a PSW.

Failure to ensure the provision of care set out in the resident's plan of care was appropriately documented placed the resident's well-being at risk due to a decreased ability to effectively assess, monitor, and evaluate interventions.

Sources: Documentation Survey Report and an interview with staff #107, Interview with staff #116.

WRITTEN NOTIFICATION: Nutritional assessments for resident after a change in health status and returned from hospital

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (4) (a)
Plan of care
s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and

The licensee failed to ensure that resident #001 received a nutritional assessment when there was a significant change in the resident's heath condition.

Rationale and Summary
A complaint was received by the Director about the fall, management and health outcome of Resident #001.

Resident #001 sustained a fractured hip after an unwitnessed fall for which they received surgical intervention and returned to the home with an incision. The resident's electronic health care record indicated a dietician referral was sent on readmission. Assessments record indicated a dietitian assessment was completed on the 18th of July 2024, seven days after readmission.

A review of the home's referral to dietitian and/or dietary manager Policy indicates "Diet needs to be reassessed as a result of changes in health status, return from hospital, new diagnosis of dysphagia, changes in dentition, improvement in health".

In an interview with staff #113, they indicated reviewing the diet order created by the receiving nurse that was in place for resident #001. They also indicated dietitian assessments are based on information received from the hospital i.e., a change in dietary need, a change in diet for the resident, and a week's requirements of observation of the resident. They confirmed an assessment was not completed

because interventions in the care plan that was in place prior to surgery was adequate. However, upon reviewing the care plan, there was no nutrition/diet care plan in place for the resident before surgical intervention.

By not ensuring resident #001 received an assessment by the dietician delayed interventions to promote healing of surgical wound.

Sources: Care Plan, interview with staff #113, dietitian and/or dietary manager Policy, PCC assessment/referral documentation.

WRITTEN NOTIFICATION: General Requirements

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

Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to resident #002 under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Rationale and Summary
A CIR was submitted to the Director for a resident-to-resident assault causing injury. Residents #002 and #003 were outside using the smoking booth when resident #003's one to one support observed resident #003 punch resident #002 in the head and neck area repeatedly.

RN #109 documented head to toe assessment, HIR and pain assessment was completed. RN #109 confirmed they could not provide HIR completed for resident #002.

The homes policy named "Head Injury Routine" states that an HIR is initiated each time a resident sustains an injury to the head (abrasion, cut, swelling, bump, or sudden onset of vomiting) following a fall or impact with an object.

Failure to complete an HIR for resident #002 put them at risk for injury.

Sources: review of home policy HIR VII-G-10.22 and interview with staff.

WRITTEN NOTIFICATION: Skin and wound assessments using a clinically appropriate instrument specifically design for skin and wound

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

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that resident #001 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically design for skin and wound upon return from the hospital.

Rationale and Summary
A complaint was received by the Director about the fall, management, and health outcome of Resident #001.

Resident #001 sustained a fractured hip after an unwitnessed fall for which they received surgical intervention and returned to the home with an incision.

The resident's electronic health care record indicated the resident did not receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically design for skin and wound.

A review of the home's Skin and Wound care policy indicated Skin and Wound Care Protocols will be initiated according to best practices.

RANO best practice recommendation 1.1 recommends "A head-to-toe skin assessment should be carried out with all clients at admission, and daily thereafter for those identified at risk for skin breakdown. Particular attention should be paid to vulnerable areas, especially over bony prominences."

Staff #107 indicated the expectation in the home was for every resident to receive a skin and wound assessment on readmission and an ongoing weekly skin assessments for residents exhibiting skin breakdown. They also acknowledged that there is no documentation of weekly skin assessments for resident #001 using a clinically appropriate assessment instrument specifically design for skin and wound in PCC.

By not ensuring resident #001 received a skin assessment by a member of the registered nursing staff upon their return from hospital, and an ongoing weekly skin assessment, using a clinically appropriate assessment instrument specifically design for skin and wound; placed the resident at risk of having areas of altered skin integrity go unnoticed and/or untreated.

Sources: Resident #001's progress notes, assessment documentation, and interview with staff #107.

WRITTEN NOTIFICATION: Documentation of every two hours reposition

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that resident #001, who was dependent on staff for repositioning, was repositioned every two hours or more frequently.

Rationale and Summary
A complaint was received by the Director about the fall, management, and health outcome of Resident #001.

Staff #107 acknowledged the resident was to be repositioned every 2hrs as per the care plan. They indicated the resident should have been turned every 2hrs and it should have been documented in POC. They also confirmed the documentation is inconsistent with the task and cannot confirm if the task was carried out as per the care plan.

Record review of the documentation review survey reports indicated resident #001 was not reposition every 2hrs (Q2hrs) as per the care plan. The record also indicated staff signing off completion of turning and reposition at the beginning of the shift in anticipation of completion of the task.

Failure of the home to ensure resident #001 was repositioned every two hours did not promote wound healing and lead to coccyx deterioration.

Sources: interview with staff #107, Survey reports, care plan.

COMPLIANCE ORDER CO #001 Food production

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78 (3).

The inspector is ordering the licensee to comply with a Compliance Order:
1) The nutrition service manager (NSM) or management designate will provide in person education to all the dietary aids on:

- Proper hand hygiene during service
- Appropriate use of gloves during service
- Proper food handling during service
- The use of appropriate serving utensils during food service.

The home will keep a documented record of the education provided, the names of the staff that attended, the date they attended, provide the documentation upon request of the Inspector.

2) The NSM or management designate will conduct audits of food service for all meals for four weeks to ensure proper handling, serving, and hand hygiene of dietary aids at mealtimes. The home will keep documented records of the audit, the date of the audit, meal type, dining room location and corrective action.

Weekly, the NSM will analyze the audits and provide further corrective action to staff based on trends observed.

Keep a documented record of the weekly analysis completed, any trends identified and what corrective action occurred.

Provide the audits upon request of the inspector.

Grounds

The licensee has failed to prevent adulteration and contamination of food during service.

Rationale and Summary

During an IPAC observation of hand hygiene practices at lunchtime, staff member #114 was seen wearing gloves while setting up for service. They touched serving surfaces, menu books, and tongs, and used the same gloves to serve bacon and buns without changing them or performing hand hygiene.

Staff member #114 was also observed removing buns from the bag and subsequently placing them back on it before serving.

In an audio-recorded interview, Staff #114 confirmed that the gloves used for setup were used to touch the serving surface and menu books, as well as to serve bacon and buns during service.

Staff #115 acknowledged that gloves are not to be used during service, tongs are to be use for serving bacon and buns, and proper food handling and hand hygiene protocols should be adhered to throughout the service.

Failing to ensure the appropriate use of gloves and serving utensils, and proper hand hygiene during service, can lead to contamination of food and the spread of food borne illnesses.

Sources: IPAC hand hygiene observations, interviews with staff #114, and #115.
This order must be complied with by February 14, 2025

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

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.