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

Public Report

Report Issue Date: February 27, 2025

Inspection Number: 2025-1116-0001

Inspection Type:
Other
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): February 19, 20, 24, 25, 26, 27, 2025

The following intake(s) were inspected:

- Intake: #00133269 - CI 2605-000042-24 - Fall of resident resulting in transfer to hospital
- Intake: #00133551 - Follow-up #01 - CO #001 / 2024-1116-0004, O. Reg. 246/22, s. 78 (3) (b) Food production due February 14, 2025
- Intake: #00136036 - Complaint on behalf of resident re: assessment of resident prior to transfer to hospital
- Intake: #00136100 - CI 2605-000001-25 - Improper/incompetent care of resident
- Intake: #00138174 - Complaint regarding safety and responsive behaviour
- Intake: #00139089 - Outstanding Emergency Planning Annual Attestation

The following intakes were completed in this inspection:

- Intake: #00139368 - CI 2605-000004-25 - Fall of resident resulting in fracture
- Intake: #00137931 - CI 2605-000002-25 - Fall of resident resulting in laceration

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1116-0004 related to O. Reg. 246/22, s. 78 (3) (b)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 267 (2) (a)
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;

On Feb 26 2025, Resident's Visitor log book updated to include visitor's contact number.

Date Remedy Implemented: February 26, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the plan of care for resident #003 provided clear directions to staff for falls interventions.

The plan of care for resident #003 did not include risk level for falls, and commode at bedside, and interventions of bed alarm and toileting schedule that were in the post fall assessment were also not included.

The Associate Director of Care (ADOC) acknowledged that the plan of care for resident #003 did not provide clear directions for staff.

Sources: Resident #003's health records Fall Prevention and Management Policy #VII-G-60.0, revised February 2023, interviews with Personal Support Worker (PSW) , Physiotherapist #119, Registered Nurse (RN) #120, Director of Care (DOC) #102 and Associate Director of Care (ADOC)#104

WRITTEN NOTIFICATION: Behaviours and altercations

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The licensee has failed to ensure that there were interventions in place for residents who were at risk of harm from a co-resident exhibiting responsive behaviours, and that the risk of altercations and potentially harmful interactions between and among residents was minimized.

Resident #005 did not receive 1:1 monitoring on evening / day shifts in January and February, 2025 which put co-residents at risk of harm.

Sources: IL-0136276-CE, resident #005 clinical record, interviews with DOC, BSO lead, complainant #117

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 (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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 9.1 (b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure routine practices and additional precautions in the IPAC program are followed as related to hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact). On a specific day in February, 2025, RPN #112 picked up an item off the floor then handled the resident's food and did not perform hand hygiene as required.

Sources: Observation and interviews with RPN #112 and IPAC Lead #105

WRITTEN NOTIFICATION: Reporting and complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the

home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
ii. an explanation of,
A. what the licensee has done to resolve the complaint, or
B. that the licensee believes the complaint to be unfounded, together with the reasons for the belief, and

The licensee has failed to ensure that when a verbal complaint was made to the licensee that the complainant was provided with an explanation of what was done to resolve the complaint.

A complainant submitted a verbal complaint to the licensee on January 27, 2025 related to safety concerns regarding a resident and did not receive a written response after an investigation into the incident was completed.

Sources: IL-0136276-CE, resident #005 clinical record, LTC home's complaint file, interviews with complainant, DOC

WRITTEN NOTIFICATION: Dealing with complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (c)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;

The licensee failed ensure that a documented record was kept in the home that included, the type of action taken to resolve the complaint, including the date of the

action, time frames for actions to be taken and any follow-up action required.

A review of documentation completed after the home's investigation of the complaint failed to demonstrate a record of action taken to resolve the complaint including any follow-up action required. The Administrator indicated that specific follow-up actions had not been created to resolve the complaint.

Sources: Critical Incident Report #2605-000001-25, email response to complainant, resident #002's clinical record, interview with Administrator

WRITTEN NOTIFICATION: Additional requirement, s. 26 of the Act

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 109 (1)
Additional requirements, s. 26 of the Act
s. 109 (1) A complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

The licensee failed to immediately report a complaint to the Director when a substitute decision maker (SDM) for a resident expressed concerns about risk of harm when the resident was not transferred to hospital for assessment when they first became ill.

On a specific date in December, 2024 resident #002 was transferred to hospital after staff assessment of an acute change to their condition. The SDM had expressed ongoing concerns to staff about deterioration in resident #002's condition that they felt were not addressed by staff prior to the acute event. The SDM contacted the Administrator with a verbal complaint on the day resident was

transferred to hospital.

Sources: Critical Incident Report #2605-000001-25, resident #002's clinical record, LTC home's investigation file, interviews with Administrator, Nurse Practitioner

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. iii.
Licensees who report investigations under s. 27 (2) of Act
s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
iii. names of staff members who responded or are responding to the incident.

In making a report to the Director under subsection 27 (2) of the Act, the licensee failed to provide the names of staff members who were present or discovered an incident of alleged neglect.

The Administrator indicated that a Critical Incident Report #2605-000001-25 submitted for alleged improper/incompetent treatment did not provide the names of care staff members involved in care of resident #002 on a specific date in December, 2024.

Sources: Critical Incident Report 2605-000001-25, interview with Administrator

WRITTEN NOTIFICATION: Attestation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to ensure that the Emergency Attestation Form was submitted annually to the Director.

Review of the Emergency Planning Attestation Form indicated that it had been completed on December 16, 2024 and that review by Ministry staff indicated that it had not been submitted by year end 2024 as required.

Sources: Emergency Planning Attestation Form, documentation by co-inspector

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order []:

1.The IPAC Lead is required to develop a written plan outlining responsibilities for checking and restocking PPE supply caddies on each shift. This plan must designate

specific individuals responsible for monitoring and replenishing supplies. It must address procedures for promptly replacing PPE caddies in the event of temporary interruptions, such as fire drills or other situations requiring hallways to be cleared. A checklist must be developed for staff to follow when a resident is placed on, or removed from precautions. This checklist should include but not be limited to, the following:
When a resident is placed on precautions:

- Assigning a designated contact person(s) to post appropriate precaution signage, specifying which bed is affected.
- Stocking PPE supply caddies and placing them at the room entrance.
- Setting up a disposable bin for PPE

When a resident is removed form precautions:

- Assigning a designated contact person(s) to notify housekeeping to clean the room.
- Ensuring signage and PPE caddies are removed.

2. All direct-care staff must be trained on this process. Document and maintain a written record of the education provided, the dates the education was provided, the staff members that attended the education, and signatures of the staff members acknowledging their understanding of the education they received.

3. The IPAC Lead or designate shall develop an audit sheet and use this audit sheet to conduct daily audits of the resident units, over the course of two weeks. This is to ensure that residents on additional precautions have the sufficient PPE supplies in caddies by room doors, disposable bins, and appropriate signage posted or removed.

The daily audit sheet will contain:

- The individual completing the audit

- Rooms requiring additional precautions signage and PPE caddies

- Corrective actions taken if caddy with sufficient PPE not present and/or additional precautions signage is not posted or removed

- The names of staff if education was provided.

4. All audits and education records will be retained and made available to Inspectors upon request.

Grounds

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director was complied with.

In accordance with Additional Requirement 6.1 under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure mandatory PPE supplies were available and accessible by staff while attending to a resident on contact precautions. On a specific date in February, 2025 three resident rooms did not have PPE caddies. Two resident rooms did not have disposable bins. Failure to ensure mandatory PPE supplies are available and accessible by staff while attending to a resident on precautions can significantly increase the risk of infection transmission among residents and staff.

Sources:

Observations and interviews with PSW #106, ADOC #104, IPAC Lead #105

This order must be complied with by

May 9, 2025

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.