Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 5, 2021	2021_784762_0017	007918-21	Other

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South Whitby ON L1N 9W2

Long-Term Care Home/Foyer de soins de longue durée

Glen Hill Terrace
80 Glen Hill Drive Whitby ON L1N 7A3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): June 9-11 and 14-15, 2021

The following intake was completed in this Post-Occupancy inspection:
Log in relation to Post-Occupancy inspection, temperature in the home and infection control

During the course of the inspection, the inspector(s) spoke with the Administrator, Environmental Service Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses(RPNs), Housekeeping Staff(ES) and Personal Support workers (PSWs)

During the course of this inspection the inspector observed infection prevention and control practices, monitoring of air temperature, resident and staff interactions, and conducted observation on resident home areas.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home maintained at a minimum of 22 degrees Celsius

A review of the Long-Term Care Home's (LTCH) documented temperature records was conducted. During this review, it was noted that the temperature was below 22 degrees celsius, in multiple resident rooms during multiple times. Administrator #102 confirmed that the temperatures were below 22 degrees celsius. As a result, residents were at risk for having negative effects related to cold temperature.

Sources: temperature logs; Interview with Administrator #102 [s. 21.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor.

A review of the LTCH’s documented temperature records was conducted. During this review, it was noted that temperatures were not measured and documented on multiple dates in resident common areas including, the lounge, dining area, or corridors. In an

interview, Administrator #102 confirmed the temperature was not measured as it was not recorded. Failing to ensure that the temperature was measured and documented in the common areas in the home increased the risk of heat related illness for the residents.

Sources: temperature logs; Interview with Administrator #102 [s. 21. (2) 2.]

3. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area.

A review of the LTCH's documented temperature records was conducted. During this review, it was noted that temperatures were not measured and documented on multiple dates in designated cooling areas. In an interview, Administrator #102 confirmed the temperature was not measured as it was not recorded. Failing to ensure that the temperature was measured and documented in the designated cooling areas in the home increased the risk of heat related illness for the residents.

Sources: temperature logs; Interview with Administrator #102 [s. 21. (2) 3.]

4. The licensee has failed to ensure that the temperatures were required to be measured under subsection (2) documented once every afternoon between 12 p.m. and 5 p.m.

A review of the LTCH's documented temperature records was conducted. During this review, it was noted that temperatures were not being measured and documented between the hours of 12 pm to 5 pm on multiple dates in two resident rooms in two different parts of the home. Additionally, temperatures were not measured and documented on multiple dates in common and designated cooling areas. In an interview, Administrator #102 confirmed the temperature was not recorded between 12 pm to 5 pm on multiple dates. Failing to ensure that the temperature was measured and documented in between the times of 12 pm and 5 pm in the home, increased the risk of heat related illness for the residents.

Sources: temperature logs; Interview with Administrator #102 [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperature in the home maintained at a minimum of 22 degrees Celsius, that the temperature measured and documented in writing in at least two resident bedrooms in different parts of the home, common area and designated cooling areas and that temperatures are measured and documented between 12 PM and 5 PM, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program, specifically in relation to staff assisting residents for hand hygiene prior to meals.

A review of the Long-Term Care homes (LTCH) infection control program and policy, and an interview with ADOC #100, indicated that the residents are to be assisted with hand hygiene prior to meals. Observations conducted on multiple dates, in various dining rooms indicated that residents were not being assisted with hand hygiene prior to and after meals. As a result, this put the residents at minimal risk of harm for spreading or ingesting pathogens.

Sources: The LTCH's hand hygiene policy; Observations conducted on multiple dates in multiple areas; Interview with ADOC #100 [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, specifically in relation to assisting residents for hand hygiene prior to meals., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. 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. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff.

During the initial tour of the facility, it was observed that a clean utility room door was being propped open with a small piece of cardboard paper. The room contained daily use items including razors, deodorants, linen, lift batteries, gloves, foam, combs, toothpaste and masks. In separate interviews, PSW #101 and Administrator #102, indicated that this was a non-resident area and hence, required to be locked. As a result, the issue was resolved immediately, and there was no harm to any residents.

Sources: Observations; interviews with PSW #101 and Administrator #102 [s. 9. (1) 2.]

Issued on this 14th day of July, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.