Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Oct 4, 2021	2021_882760_0035	011910-21, 012291-21, 014265-21	Critical Incident System

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

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 21, 22, 23, 27, 28, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to a fall;
A log was related to a significant change in condition;
A log was related to an allegation of neglect.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), the Behavioural Supports Ontario Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Long-Term Care (LTC) Consultants and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
3 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for three residents.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Head Injury", dated April 2021. The policy stated any residents who sustains a head injury or an unwitnessed fall will have a head injury routine (HIR) initiated.

A review of the progress notes indicated that a resident sustained a fall. The resident communicated an injury after this fall. A HIR was initiated for the resident. A review of the HIR demonstrated that it was not completed in accordance to the home's policy. The RPN did not recall why they did not complete the HIR in accordance to the home's policy. The LTC Consultant confirmed the staff should have completed the resident’s HIR in accordance to the home’s policy.

Sources: The home’s policy, “Head Injury”, dated April 2021; Review of a resident’s HIR and progress notes; Interviews with an RPN, the LTC Consultant and other staff. [s. 8. (1)]

2. A resident sustained a fall and according to the progress notes, the resident was found with an injury after their fall. The resident was later assessed by a nurse practitioner (NP). The NP wrote that the resident was diagnosed with an injury and had ordered the staff to continue the resident’s HIR. A HIR was not found related to this fall. The LTC

Consultant stated in accordance to the home’s policy, the staff should have completed a HIR in accordance to the home's policy.

Sources: The home’s policy, “Head Injury”, dated April 2021; Review of a resident’s progress notes, medical chart; Interview with the LTC Consultant and other staff. [s. 8. (1)]

3. A resident had sustained a fall. A review of the progress notes of this fall indicated that a HIR was initiated. A review of this HIR indicated that it was not completed in accordance to the home's policy. The RN stated they were unable to conduct the HIR checks for the resident in accordance to the home's policy. The LTC Consultant stated the home’s expectation would be to have it completed for the resident in accordance to the home’s policy.

The failure to complete a HIR for the residents, after a fall and/or a fall with an injury may result in changes in the resident’s condition that staff may not be able to immediately respond to if they did not complete a HIR in accordance to the home’s policy.

Sources: The home’s policy, “Head Injury”, dated April 2021; Review of a resident’s progress notes, HIRs; Interviews with the RN and the LTC Consultant. [s. 8. (1)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that an RPN used safe transferring techniques with a resident, after they sustained a fall.

A review of the progress notes indicated that an RPN had found a resident with an injury after their fall. According to the home's policy titled "Lift Procedures", dated April 2021, staff are to transfer residents in a manner aligned with the home's policy. The RPN stated they had performed a transfer with the resident. The LTC Consultant stated that in accordance to the home's policy and this resident's safety needs, the staff should have used a technique to transfer this resident. The LTC consultant added that the transfer used by the staff may have further aggravated the resident's injuries.

Sources: Home's policy titled, "Lift Procedures", dated April 2021; A resident's progress notes; Interviews with an RPN, the LTC Consultant and other staff. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident received sufficient changes to their continence care product to remain clean, dry and comfortable.

An interview with a PSW indicated they had found the resident in a soiled manner. The PSW stated they had never found the resident in this state and that it was inappropriate for the resident to have been left in the condition they were found. According to the home's investigation, an agency PSW had communicated to a PSW in the home about the resident's care but the PSW had misinterpreted what the agency PSW had meant. The PSW stated that the agency PSW provided care twice to the resident on their shift but on the third round, the PSWs did not check to see if the resident required continence care. The LTC Consultant stated the home's expectation would have been for staff to have provided care to the resident on third round. The failure to provide sufficient continence care to the resident resulted in them being found in an undignified condition.

Sources: Home's investigation notes; Interviews with two PSWs, the LTC Consultant and other staff. [s. 51. (2) (g)]

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, (g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to strategize different types of approaches in revising a resident's plan of care related to their fall prevention interventions.

A review of the resident's most recent care plan indicated they would use a certain type of a fall prevention equipment. An interview with the PSW indicated that the resident would often refuse to have this specific equipment applied. The PSW and an RPN said the home uses an alternative equipment for falls prevention but this alternate equipment was not tried for this resident. The LTC Consultant confirmed the home used this alternate equipment and stated this should have been a strategy tried by the staff if the resident did not prefer the original equipment.

Sources: A resident's care plan; Interviews with a PSW, an RPN and the LTC Consultant. [s. 6. (11) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure a resident had their fall prevention intervention readily available to be applied.

A review of the resident’s care plan indicated they had a fall prevention intervention applied to them. An observation demonstrated that the resident did not have their intervention applied. An interview with the PSW indicated they were unable to find this fall prevention intervention to be applied for the resident and was unable to contact the nurse on the unit to find another one to use. The PSW stated they were aware that this resident required this fall prevention intervention. The LTC Consultant stated the staff should have made the resident’s fall prevention intervention readily available to be applied. Failure to have this intervention applied for the resident may result in further injury to the resident if they had sustained a fall.

Sources: Observation on the resident; Interviews with a PSW, the LTC Consultant and other staff. [s. 49. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a pain assessment was completed for a resident when initial interventions were ineffective at controlling their pain.

A review of the progress notes indicated that an RN had noticed that the resident was complaining of pain. The RN provided an intervention, but it was not effective. A review of the assessments did not show that staff had completed a pain assessment on the resident after initial interventions were not effective. The RN stated that they did not complete a pain assessment with the resident and ideally, they should have done it. Failure to conduct a pain assessment on the resident after initial interventions were not effective may have resulted in the lack of development of further interventions to manage the resident's pain.

Sources: A resident's progress notes, assessments; Interviews with an RN and other staff. [s. 52. (2)]

Issued on this 6th day of October, 2021

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

Original report signed by the inspector.