Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

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Original Public Report

Report Issue Date June 21, 2022
Inspection Number 2022_1629_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Glen Hill Terrace Christian Homes Inc.

Long-Term Care Home and City
Glen Hill Terrace, Whitby

Lead Inspector
Julie Dunn (706026)

Additional Inspector(s)
Catherine Ochnik (704957)

Choose an item.
Julie Dunn
Digitally signed by Julie Dunn
Date: 2022.06.21 14:17:10 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 19, 20, 24, 25, 26, 27, 30, 31, 2022

The following intake(s) were inspected:

- Intake #005772-22: Follow up on a high priority CO #007 for inspection 2022_598570_0001 regarding nutrition and hydration with a compliance due date of April 21, 2022. The CO is related to O. Reg 79/10 s. 68 (2).
- Intake # 006047-22 related to an enteric outbreak in the long-term care home.
- Intake #019120-21 (Complaint) related to medication management.
- Intake #006006-22 (Complaint) related to bathing and nutrition.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 68 (2)	2022_598570_0001	007	704957
Choose an item.				
Choose an item.				

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

O. Reg. 79/10 s. 131 (2) The licensee failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

A resident had a medication ordered to be given each day at a specific time. The medication administration records showed the medication was not signed as administered on two dates, and there were no progress notes documented to provide a rationale. The resident stated that there was a mistake and they did not receive the medication on a specific date and reported that it had an impact.

The staff interviewed stated they received communication about the medication not given on a specific date, and they had a communication with the pharmacy stating that there wasn't any of the medication available to be administered on a specific date for the resident.

Impact or risk

In failing to administer the medication as ordered for the resident, it had an impact, and the risk to the resident was low.

Sources:

Interviews with the resident and with staff.

The resident's clinical record, including medication orders, medication administration records, and progress notes.

WRITTEN NOTIFICATION [MEDICATION MANAGEMENT]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

O. Reg. 79/10 s.135. (1) The licensee failed to ensure that every medication incident involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A resident was prescribed a medication to be given each day at a specific time. The documentation showed the resident did not receive the scheduled medication as ordered on specific dates, and there were no progress notes to provide a rationale. The resident stated they did not received the medication as ordered on a specific date.

The staff interviewed stated they were aware and they had a communication with the pharmacy regarding the availability of the resident's medication on a specific date. Staff interviewed stated if a medication is not given as scheduled, there should be a progress note and an incident report. The staff acknowledged the appropriate process was not followed and they do not have medication incident reports for the specific dates when the resident did not receive the scheduled medication as ordered.

Impact or risk

In failing to document the medication incidents, it resulted in no record of the medication incidents and no record of reviewing the medication incidents, and the risk to the resident was low.

Sources:

Interviews with the resident and with staff.

The resident clinical record, including medication orders, medication administration records, and progress notes.

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control (IPAC) 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.

The local public health unit declared the long-term care home to be in an outbreak of COVID-19 on a specific date.

Positive COVID-19 PCR test results were received for a resident. The resident remained on isolation due to their COVID-19 positive test. The resident's room was located in an outbreak area of the home. A sign posted on the door of the resident's room stated Contact & Droplet Precautions.

In interviews with staff, they stated N95 masks and eye protection were mandatory in outbreak areas of the long-term care home.

There was a sign posted on the double door entry to a resident area stating the area was in outbreak, N95 masks and face shields or goggles were mandatory beyond the double doors. A personal protective equipment (PPE) station was set up outside the double door entry, including gowns, gloves, N95 masks, face shields, alcohol based hand rub, and Accel wipes. A staff was observed to be wearing a blue procedure mask and no eye protection walking down the hallway past resident rooms in the outbreak area. When the inspector asked the staff about the PPE requirements, the staff stated their size of N95 masks were not available. Inspector pointed at multiple boxes of various sizes of N95 masks on the table at the double doors. The staff stated they were previously not aware that their size was available on the table.

A bulletin board in the long-term care home stated an area of the home remained in outbreak, staff were to continue to wear N95 and eye protection past the double doors, gowns and gloves were to be worn in resident rooms as indicated on the signs on their doors.

There was a sign posted on the double door entry to a resident area stating the area was in outbreak, N95 masks and eye protection required to be worn in the area. A Contact & Droplet Precautions sign was observed on the door of a resident's room and a PPE caddy located outside of the resident's room was empty. A staff was observed in the hallway of the resident area wearing an N95 mask and no eye protection. When asked if they had eye protection available to them, the staff stated yes they have eye protection and they only wear it when entering the resident's room, and they're not afraid of COVID. A staff was observed carrying take-out containers from the servery, through the double door entry of the resident area, to resident rooms. The staff was wearing a blue procedure mask and no eye protection. When asked if they were aware of the sign posted on the doors, stating N95 and eye protection required due to outbreak in this area, the staff continued walking down hallway, then returned wearing a face shield and an N95 mask over top of the blue procedure mask. The staff pushed an empty cart to the servery area, loaded the cart with take-out containers of lunch meals and pushed the loaded cart past the double doors to deliver the take-out containers to the resident rooms. The staff entered the resident's room with a take-out container, without donning a gown or gloves, then exited the room.

Impact or risk

In failing to ensure that all staff participate in the implementation of the IPAC program by wearing appropriate PPE in outbreak areas of the home, there was moderate risk to residents of further spread of COVID-19 in the long-term care home.

Sources:

Clinical record for the resident; COVID-19 Outbreak Line List; Bulletin Board.
Interviews with staff.
Observations in resident areas.