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: June 8, 2023	
Inspection Number: 2023-1629-0002	
Inspection Type: Complaint	
Licensee: Glen Hill Terrace Christian Homes Inc.	
Long Term Care Home and City: Glen Hill Terrace, Whitby	
Lead Inspector Carole Ma (741725)	**Inspector Digital Signature** Hui - Chia Carole Ma Digitally signed by Hui - Chia Carole Ma Date: 2023.06.28 09:13:12 -04'00'
Additional Inspector(s) AngieM King (644)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 9 - 12, 15 - 19, 23 and 24, 2023

The following Complaint Intakes were inspected:
·Two anonymous complaints related to concerns of neglect, quality care, availability of supplies, short staff, MOH inspection outcomes and safe and secure home
·Two complaints related to concerns of improper medication administration, bowel management, medication administration, food.

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Safe and Secure Home
Skin and Wound 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)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that the care set out in the plan of care is reviewed and revised at least every six months and at any other time when resident's care needs change or care set out in the plan is no longer necessary.

Rationale and Summary
In an interview, a resident indicated their preference for their assigned bath, bed bath.

A resident's Point Click Care (PCC) records were reviewed, the care plan, Kardex did not identify their bath preference, and referred to the Bath List for the scheduled bath days, the Point of Care (POC) record, Personal Support Worker (PSW) documentation indicated the resident's preference for their assigned bath and specific bath day and time. The resident's specific home area (RHA) Bath List dated April 2023 indicated the correct bath day, their bath preference, not the correct bath time and the electronic medication administration record (eMAR) did not indicate the correct bath day and time for nail care.

Three PSWs stated in separate interviews the resident's preference and their assigned bath days and correct bath time. The Registered Practical Nurse (RPN) stated that one of the resident's bath days' time was changed one month ago, they had notified the Resident Assessment Instrument (RAI) Coordinator, but the Bath List was not updated, nor the eMAR, care plan and kardex.

The RAI Coordinator was not aware of the reason for the resident's changed bath time on the specific bath day, they stated the home's expectation is if the resident's POC was updated, then the resident's care plan, kardex, eMAR and the RHA's Bath list should have been updated in April 2023 when the change occurred.

There was no impact and low risk to the resident.

Sources: Inspector observations, resident records, RHA bath list, interviews with PSWs, and RAI

Coordinator. [644]

Date Remedy Implemented: May 18, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's power of attorney (POA) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint on a specific date that a resident was not administered a medication as prescribed.

The medication was ordered by the Nurse Practitioner (NP) on a specific date and was scheduled to start the next day. Instead, the resident received their first dose in the home approximately five weeks later.

The pharmacy entered the medication into the resident's eMAR on the same day it was ordered, and indicated the medication required payment by the POA before it could be sent to the home. The pharmacy's Designated Manager (DM) acknowledged the pharmacy did not contact the POA in accordance with their internal process regarding the payment, and that a paper note sent to the home indicating the same message was not received. Nursing staff signed off the medication daily in the eMAR as being not available during this approximate five-week period.

In the home's Incident Investigation report, signed and dated by the Director of Care (DOC), RPN #113 stated that they had spoken with the POA on several occasions, regarding the need to call the pharmacy to pay for the medication. RPN #113 acknowledged that they failed to document any of these conversations in the resident's medical records. The DOC provided in-time counseling to RPN #113 regarding documentation practices, specifically noting that progress notes of the discussions should have been done.

From independent review of the resident's medical records in PCC, Inspector #741725, Registered Nurse (RN) #106 and the Assistant Director of Care (ADOC) confirmed there was no documentation of RPN #113's conversations with the POA.

In an interview with the POA, during which they referred to handwritten notes in a calendar, they stated

they were first informed by RPN #113 one month after the medication was ordered, that the resident had not been receiving the medication. Once they were made aware, the POA called the pharmacy. The POA also stated that they would have acted sooner to have ensured continuity of this medication if they were made aware of the situation.

Therefore, failing to inform the POA that the resident's medication required an additional payment, and that it had not been administered as scheduled, resulted in a delay of the resident continuing their scheduled medication as prescribed.

Sources: Complaint report, resident's medical records, Incident Investigation report, interviews with pharmacy's DM, POA, RN #106 and the ADOC. [741725]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, had been assessed and received a skin assessment by a member of the registered nursing staff.

Rationale and Summary
The MLTC received an anonymous complaint related to concerns of altered skin integrity, specific to a resident.

Observations conducted by the Inspector on specific dates in May 2023, noted a resident with a specific identified skin condition. In an interview with the resident, they indicated a second specific change in skin integrity that had occurred for several weeks and was unaware of the specific dates they first occurred.

A review of the resident's current written plan of care indicated the resident was high risk of alteration in skin integrity due to specific medical conditions and medication. A review of the resident's electronic documentation, skin assessments indicated the resident had no assessments completed or progress note documentation related to the identified skin conditions.

A review of the home's skin and wound care management policy #VII-G-20.10, last revised February 2023, indicated that each resident will have a skin assessment and where indicated, a treatment plan for the maintenance of skin integrity and wound management, specifically the PSWs each shift, will report

abnormal or unusual skin conditions to the registered nursing staff, e.g., red, or open areas, blisters, bruises, tears, rashes, scratches. Registered Staff would conduct a skin assessment for resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds.

A PSW indicated that they had reported a specific skin alteration to the RPN charge nurse, but they did not recall the specific date when this was done. The RPN stated that they were unaware of changes to the resident's skin.

The Skin and Wound Lead and the ADOC indicated that PSW staff are to report to the registered staff a resident's altered skin integrity. The registered staff are required to complete a skin assessment and document on the altered skin integrity in a skin observation progress note. The ADOC confirmed that the resident had no assessments or progress note documentation completed for the identified skin conditions.

There was no impact and low risk to the resident during the inspection, the noted changes in skin integrity were healing.

Sources: Inspector's observations, resident records, resident, PSW, RPN, Skin and Wound Lead and ADOC interviews. [644]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a) (i)

The licensee has failed to ensure a specific medication incident was included in the home's quarterly review of all medication incidents in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary
The MLTC received a complaint on a specific date that a resident was not administered a medication as prescribed.

Section 1 of the Ontario Regulation 246/22 defines a medication incident as a preventable event associated with the prescribing, ordering, dispensing, packaging, storing, labelling, preparing, administering, or distributing of a drug, the monitoring of the use of the drug by the resident or the

transcribing of a prescription, and includes, an act of omission or commission, whether or not it results in harm, injury or death to a resident.

The medication was ordered by the NP on a specific date and was scheduled to start the next day. Instead, the resident received their first dose in the home approximately five weeks later.

The Administrator stated this incident was not reviewed in the home's quarterly Professional Advisory Committee/Medical Advisor Committee (PAC/MAC) meeting, held on a specific date, because the home did not view it as a medication incident. The Administrator stated that the home was under the impression that the POA had been contacted by pharmacy, as per their process, to confirm payment and that the home was waiting for the POA to take this next step.

The pharmacy entered the medication into the resident's eMAR on the same day it was ordered, and indicated the medication required payment by the POA before it could be sent to the home. The pharmacy's DM acknowledged pharmacy did not contact the POA in accordance with their internal process regarding the payment, and that a paper note sent to the home indicating the same message was not received. Nursing staff signed off the medication daily in the eMAR as being not available during this approximate five-week period.

In the home's Incident Investigation report, signed and dated by the DOC, RPN #113 stated that they had called the pharmacy on or about four days after the medication order was made, and had spoken with the POA on several occasions regarding the additional payment for the medication. RPN #113 acknowledged that they failed to document any of these conversations in the resident's medical records. The DOC provided in-time counseling to RPN #113 regarding documentation practices, specifically noting that progress notes of the discussions should have been done.

From independent review of the resident's medical records in PCC, Inspector #741725, RN #106 and the ADOC confirmed there was no documentation of RPN #113's conversations with the pharmacy or the POA.

In an interview with the POA, during which they referred to handwritten notes in a calendar, they stated they were first informed by RPN #113 one month after the medication was prescribed, that the resident had not been receiving the medication. Once they were made aware, the POA called the pharmacy. The POA also stated that they would have acted sooner to have ensured continuity of this medication if they were made aware of the situation.

The prescribing NP no longer worked in the home at the time of inspection. There was no supporting documentation that they had been informed that the resident was not receiving the medication until

approximately five weeks after the medication order was made. At a specific time, an RN wrote in the resident's medical records that the NP was informed the resident did not have the medication for a month, and that supply was now available in the home.

In an interview with the resident's attending physician, Physician #108 stated that if a medication is delayed, they would expect to receive a notification of this within a couple of days or definitely by the end of a week. Physician #108 had no recollection of being made aware the medication was delayed and stated that they did not see any documentation indicating this in the resident's medical records. Inspector #741725 also there was no documentation indicating that Physician #108 had been informed within a week of admission, that the resident was not receiving the medication as scheduled.

In failing to identify this incident as a medication incident and including it in the home's quarterly PAC/MAC meeting, the home missed an opportunity in examining and enhancing its own policies and procedures, and potentially providing additional training to registered nursing staff, to ensure this type of medication incident does not reoccur.

Sources: Complaint report, resident's medical records, Incident Investigation report, PAC/MAC meeting minutes, interviews with pharmacy's DM, POA, RN #106, the ADOC and Physician #108. [741725]

WRITTEN NOTIFICATION: RESIDENT RECORDS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary
The MLTC received a complaint on a specific date that a resident was not administered a medication as prescribed.

The medication was ordered by the NP on a specific date and was scheduled to start the next day. Instead, the resident received their first dose in the home approximately five weeks later.

The pharmacy entered the medication into the resident's eMAR on the same day it was ordered, and indicated the medication required payment by the POA before it could be sent to the home. The pharmacy's DM acknowledged the pharmacy did not contact the POA in accordance with their internal process regarding the payment, and that a paper note sent to the home indicating the same message

was not received. Nursing staff signed off the medication daily in the eMAR as being not available during this approximate five-week period.

In the home's Incident Investigation report, signed and dated by the DOC, RPN #113 stated that they had called the pharmacy multiple times, beginning about four days after the medication order was made. RPN #113 acknowledged that they failed to document any conversations with pharmacy. The DOC provided in-time counseling to RPN #113 regarding documentation practices, specifically noting that progress notes of the discussions should have been done.

From independent reviews of the resident's medical records in PCC, Inspector #741725, RN #106 and the ADOC also confirmed there was no documentation of RPN #113's conversation with the pharmacy regarding the medication.

In failing to ensure the resident's medical records were kept up to date, other registered nursing staff, the NP and/or the attending physician were not made aware of the need to follow up on the medication. This contributed to the delay of the resident receiving their scheduled medication.

Sources: Complaint report, resident's medical records, Incident Investigation report, interviews with pharmacy's DM, RN #106 and the ADOC. [741725]