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**
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# Original Public Report

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| **Report Issue Date: August 6, 2024** |
| **Inspection Number:** 2024-1629-0004 |
| **Inspection Type:**<br>Critical Incident<br>Follow up |
| **Licensee:** Glen Hill Terrace Christian Homes Inc. |
| **Long Term Care Home and City:** Glen Hill Terrace, Whitby |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 23-26, and 29, 2024.

The following intake(s) were inspected:

- Three intakes related to residents' falls that resulted in injury.
- One intake related to the unexpected death of a resident.
- One intake related to Follow-up #: 1 - FLTCA, 2021 - s. 25 (1).

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1629-0002 related to FLTCA, 2021, s. 25 (1)

inspected by Julie Dunn (706026)

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
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: FLTCA, 2021, s. 6 (10) (b)**
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

Non-compliance with FLTCA s. 6. (10) (b)
The licensee failed to ensure that the plan of care was reviewed and revised when resident 002's care needs changed or care set out in the plan was no longer

necessary.

**Summary and Rationale**

A follow-up inspection related to the care and monitoring of a resident occurred. During the inspection, it was observed that the resident did not have a support companion with them.

Both the care plan and Kardex for the resident indicated that they required the companion to monitor the resident for a specified time.

A Personal Support Worker (PSW) and the Assistant Director of Care (ADOC) confirmed that the resident had previously required the intervention, but it was no longer necessary.

The ADOC acknowledged that the care plan needed to be updated as it indicated that the resident still required companion support. The ADOC indicated that the care plan should have been updated by whomever discontinued the intervention for the resident.

The ADOC updated the care plan for the resident on July 25, 2024, to reflect the changes in the resident's care needs.

**Sources**: observations, the resident's clinical records, interviews with PSW and ADOC.

Date Remedy Implemented: July 25, 2024