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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 24, 2025
Original Report Issue Date: December 20, 2024
Inspection Number: 2024-1629-0005 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Glen Hill Terrace Christian Homes Inc.
Long Term Care Home and City: Glen Hill Terrace, Whitby

AMENDED INSPECTION SUMMARY

This report has been amended to:
CO #004 (NCA-36968) was **altered and Substituted** with a Director Order.
CO #005 (NCA-36939) was Rescinded. and a new Written Notification for O. Reg 102 (9) (a) was issued

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
December 10 -13, 16, 18, -19, 2024
The inspection occurred offsite on the following date(s): December 18, 19, 2024
The following intake(s) were inspected:

- An intake related to a fall
- An intake related to abuse
- An intake related to outbreak.
- An intake related to abuse

- An intake related to outbreak
- An intake related to abuse
- An intake related to a fall
- An intake related to a complaint

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

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors In a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. 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.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when not being supervised by staff. Inspector observed on a specified home area, an RN Supervisor's Office Door, unlocked and unsupervised

with multiple nursing supplies and equipment easily accessible to residents.

Staff confirmed that the RN Supervisor's door was to be locked at all times when unsupervised and was not.

Sources: Inspector observations, and an interview with staff.

WRITTEN NOTIFICATION: Personal Items and Personal Aids

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 41 (1) (a)
Personal items and personal aids
s. 41 (1) Every licensee of a long-term care home shall ensure that each resident of the home has their personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and

The licensee shall ensure that each resident of the home has their personal items, labelled within 48 hours of admission and of acquiring, in the case of new items.

Inspector observed on a specified home area personal items that were not labelled with resident names. Staff confirmed that that the personal items located on the unsupervised carts were to be labelled with the resident's name and were not.

Sources: Inspector Observations, and an interview with staff.

WRITTEN NOTIFICATION: Required programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the home's falls prevention and management program was followed. Specifically, staff were required to complete and document HIR monitoring for a resident.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program, which includes the completion of HIR when a head injury is suspected.

Specifically, staff did not complete a head injury routine assessment when a resident fell and received a head injury.

Sources: Resident's clinical health records, interview with staff, and the homes falls prevention and management policy.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by an authorized person described in subsection (2.1),

using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment when they fell and on readmission to the home.

Sources: Resident's clinical health records and interviews with staff,

WRITTEN NOTIFICATION: Hazardous Substances

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Inspector observed cleaning chemicals in unsupervised two home area activity Rooms, within unlocked under the sink cabinets. Inspector observed in an unsupervised specified home area activity Room, an unlocked cart, key remaining in locking mechanism, that contained multiple hazardous substances.

Inspector observed in an unsupervised specified home area activity Room, a hazardous substance located on countertop. Additionally, Inspector observed in an unsupervised specified home activity Room, a food item located in an unlocked

upper cabinet.

Staff confirmed that hazardous substances throughout the home were to be locked away when unsupervised.

Sources: Inspector observations, and interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).
According to IPAC Standard, 9.1(a) for Additional Precautions, the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program, specifically, at minimum, Additional Precautions shall include evidence-based practices related to potential contact transmission and required precautions.

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Review of the home's Additional Precautions resident list indicated that a resident was under Contact Precautions. Inspector observed on a specified date , a resident did not have IPAC signage posted, PPE at the point of care or a waste bin at inside of door for doffing of used PPE.

Sources: IPAC Checklist, the home's Additional Precautions resident list, Inspector

observations, and interviews with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which they were taken to a hospital, and that resulted in a significant change in condition.

A resident received multiple injuries of unknown cause requiring treatment at hospital, interdisciplinary assessment, and a change to their plan of care.

Sources: Clinical records for a resident and interviews with staff.

COMPLIANCE ORDER CO #001 Duty to protect

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee shall:

Educate all PSWs including agency staff on Care Plans:
1- The training should cover the following topics:
• Definition of a care plan
• Purpose and importance of care plans
• How, where, and when to access care plans.
• Documentation requirements for tasks completed in care plans.
Maintain a written record of the training provided and ensure it is readily available upon request.

2- Educate all PSWs including agency staffs on safe shower chair transfer. This training is to be completed for all new staffs including agency staff and annually as part of the fall's prevention program.

Grounds
1.The licensee failed to ensure that a resident was not neglected when a staff member admitted to always showering the resident alone. This pattern of inaction resulted in the resident's fall resulting in injuries and hospitalization.

A review of the Point of Care (POC) shower documentation for several months indicates multiple Personal Support Workers (PSWs) signed off showers as a one-person physical assist task, despite the care plan specifying that it requires a two-person assist.

Also, staff admitted to being unaware that a resident required two-person assistance for showers, as they were not the primary PSW for the resident.

Failure to protect the resident from neglect resulted in a pattern of inaction by the Personal Support Workers (PSWs), leading to the resident's fall and injuries.

Sources: Incident investigation, care plan, interview with the staff, POC shower documentation.

2.The licensee failed to ensure that a resident was protected from physical abuse by a Personal Support Worker (PSW).
Section 2 (a) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Clinical health records, and the home's investigation notes, indicate that on a specified date. a resident was crying, observed to have sustained injuries, and alleged a PSW was rough when providing their care that morning.

In separate interviews with the Inspector, multiple staff indicated the home has a policy for zero tolerance of abuse and neglect and reported the allegations of abuse to their supervisor.

The Director of Care (DOC) acknowledged that the home completed an investigation and that physical abuse occurred when the PSW used physical force that was excessive and disciplined the PSW accordingly.

Failing to protect a resident from physical abuse by a PSW resulted pain and injury.

Sources: Critical incident report, **c**linical health records, home investigation notes, interviews with staff.

3.The licensee failed to ensure that a resident was protected from physical abuse by a Personal Support Worker (PSW)
Section 2 (a) of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

A resident disclosed allegations that a PSW was rough with their care on a specified dated to staff. Management staff acknowledged the home completed an investigation and substantiated the care provided was rough and terminated the PSW.

Failing to protect a resident from physical abuse by a PSW resulted in emotional distress to a resident.

Sources: Critical incident report, clinical health records, home's investigation notes, and interviews with staff.

This order must be complied with by March 21, 2025

An Administrative Monetary Penalty (AMP) is being issued on this compliance

order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #002 Compliance with manufacturers' instructions

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1- Educate All Direct Care Staff on Manufacturer Safety Information for Shower Chairs.

- Incorporate this education as an ongoing requirement in the orientation program.
- Keep a written record of the training provided and make immediately available to the inspector upon request.

2- As part of the home's preventative maintenance, develop and implement an ongoing weekly preventative maintenance shower chair audits for all home areas. The audits will include but not limited to:

- The overall working condition of the chair
- That the brakes are functional and in good working condition
- That the wheels are not loose or unstable
- The belt is in place and in good working condition.
- The arms of the chairs are in place and in good working condition.
- Ensure the audits comply with the manufacturer's safety recommendations.
- The documentation for the audits will be specific to each home area.
- Keep record of the audits and make available to the inspector upon request.

Grounds

A complaint was received by the director for a fall with injury.
The licensee failed to ensure that staff utilized assistive aids in accordance with the manufacturer's instructions while providing a shower to a resident. Specifically, a staff member repositioned a resident, resulting in the shower chair tipping and causing the resident to fall and require hospitalization for their injury.

A review of the assistive aid safety manual indicates to avoid tipping, do not shift your weight or sitting position toward the direction you are reaching.
The Licensee concluded in their findings that, even with the brakes engaged, the chair could tip when a resident was repositioned from side to side, particularly if the staff member was moving the resident away from the side on which they were standing.

Staff confirmed that staff did not follow the manufacturer's safety instructions for repositioning in the shower chair while providing shower to the resident.

Failure to follow the manufacturer's instructions resulted in the shower chair tipping, which led to the resident's fall resulting in injury.

Sources: Incident investigation, care plan, interview with the staff, clinical health records.

This order must be complied with by March 21, 2025.

COMPLIANCE ORDER CO #003 Transferring and positioning techniques

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1-The management designate will educate all PSWs including agency PSWs staffs

on safe shower chair transfer. This training is to be completed for current and new staff, including agency PSWs staff and annually as part of the fall's prevention program.
The training should cover the following topics:

- In person hands-on training and return demonstration for every make and model of all shower chairs on each floor.
- Keep a written record of the training provided and make immediately available to the inspector upon request.

2- Ensure a checklist demonstrating all the steps involved in performing a safe shower chair transfer is completed and signed by the trainee and trainer. Records are to be kept and made immediately available to the inspector upon request.
3- Conduct a shower audit that reflect the checklist demonstrating all the steps involve in performing a safe shower chair transfer and repositioning in each home area for 2 Weeks.

- The audit will include the name of the staff, the home area, the date and time, and any corrective action implemented.
- Keep a written record of the audits and make available to the inspector upon request.

Grounds
The licensee has failed to ensure that a resident was repositioned using a safe transferring and reposition device or techniques when staff repositioned them alone in the shower. A resident's plan of care indicated they required two staff during showers.

Sources: Incident investigation, care plan, interview with staff.

2The licensee failed to ensure that a Personal Support Worker used safe transferring techniques when transferring a resident.

The plan of care for a resident directs to complete mechanical lift transfers with two staff. The home's investigation notes indicate a PSW, in interview with the home, acknowledged they completed a resident's transfer alone.

Failing to use safe transferring techniques when transferring a resident may have contributed to the resident being injured.

Sources: Critical incident report, resident's clinical health records, home's investigation notes, and interviews with staff.

This order must be complied with by March 21, 2025.

(A1)
The following order(s) has been rescinded: CO #004

COMPLIANCE ORDER CO #004 Altercations and other interactions between residents

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

(A1)
The following order(s) has been rescinded: CO #005

COMPLIANCE ORDER CO #005 Infection prevention and control program

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

(A1)
The following non-compliance(s) has been newly issued: NC #013

WRITTEN NOTIFICATION: Infection Prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee has failed to ensure that, on every shift, symptoms indicating the presence of infection were monitored for specific resident's.

Two Critical Incident Report's (CIR) were received by the Director related to disease outbreaks.

IPAC Lead confirmed that during a disease outbreak, residents were monitored for symptoms of infection twice per day and the symptoms were recorded in the resident's Electronic Medication Record (EMAR).

Review of the home's Outbreak Line List's for both outbreaks, confirmed that specific residents were associated with an outbreak.
Review of EMAR's confirmed that the specific residents were not monitored on every shift during their isolation duration.

Sources: CIR, the home's outbreak line list's, electronic health records, and an Interview with IPAC Lead.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:
(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and

(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.

(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.