Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, 2017	2017_599166_0004	000701-17	Resident Quality Inspection

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 Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

CAROLINE TOMPKINS (166), CATHI KERR (641), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 10, 13, 14, 15, 16, 2017

Critical Incident Logs 029124-16, 000357-17 related to falls, 030030-16, 030546-16, 034951-16 related to controlled substance missing /unaccounted, logs 030592-16, 032526-16 related to allegations of resident to resident physical abuse and log 000719-17 related to allegations of staff to resident emotional abuse were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Residents, Resident Council President, Residents' Council Acting President, Director of Care (DOC), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), the RAI Coordinators, Program Manager, Housekeeping Staff and Staff Development Coordinator.

During the course of this inspection, the inspectors observed staff to resident interactions during the provision of care, resident to resident interactions, toured resident home and common areas, infection control practices and medication administration.
The inspectors reviewed clinical health records, the licensee's investigations documentation and the licensee's policies related to restraints, use of bed rails, resident abuse and neglect.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Related to log 000357-17

The licensee has failed to ensure that care set out in the plan of care was provided to resident #035 as specified in the plan.

A Critical Incident Report(CIR) was submitted to the Director, reporting an incident for which a resident was transferred to hospital which resulted in a significant change in the resident's health status.

Review of the CIR and clinical documentation indicated resident #035 was found on the floor. The resident's chair was not in the tilt position and the chair alarm was unclipped.

The resident was assessed post fall, transferred to hospital for further assessment and admitted for further treatment.

Resident #035's plan of care related to directions to staff when the resident was in the wheelchair indicated :
-Resident is a high risk for falls
-clip alarm to be used when up in wheelchair
-tilt wheelchair for comfort and positioning when up in wheelchair.

February 16, 2017 at 12:20 hours, Inspector #166 interviewed PSW #118, who indicated resident #035's chair was to be tilted at all time and the clip alarm to be in place whenever the resident was in the wheelchair.

February 16, 2017 at 11:45 hours, Inspector #166 interviewed PSW #124, who indicated there were written instructions with the resident that directed staff to ensure the resident's chair was tilted at all times.

PSW #124 indicated, she positioned resident #035's wheelchair in the up position(not tilted) in order to accommodate space for other residents.

February 16, 2017 at 12:30 hour, Inspector #166, interviewed the DOC, who indicated, resident #035's wheelchair was to be tilted and clip alarm in place at all times.

Resident #035's plan of care, as well as written instructions with the resident, directed staff to ensure that resident #035's wheelchair was in a tilt position at all times when the resident was in the chair.

On the date of the incident, resident #035's wheelchair was not in the tilt position, the chair clip alarm was not in place and resident #035 fell from the chair and sustained an injury. [s. 6. (7)]

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 care set out in the plan of care is provided to resident #035 as specified in the plan of care, to be implemented voluntarily.

Issued on this   21st   day of February, 2017

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

Original report signed by the inspector.