Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 28, 2020	2020_715672_0005	024045-19, 024189-19	Critical Incident System

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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 6, 9 and 10, 2020.

The following intakes were inspected during this Critical Incident System inspection:

Two Logs related to Critical Incident Reports regarding alleged incidents of resident to resident abuse.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed employee training records, schedules and several internal policies.

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Care (ADOC), RAI Coordinator, Staffing Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Nurse Practitioner (NP), family members, residents and visitors to the home.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. The licensee has failed to ensure that the resident's care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #002. The CIR indicated that on a specified date, resident #002 was observed to request assistance from staff as resident #001 was exhibiting a responsive behaviour which led to an altercation between residents #001 and #002. Resident #002 sustained identified injuries. A second CIR was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #003. The CIR indicated that on a specified date, a staff member was to provide resident #001 with an identified intervention and the staff member went on break and did not provide the intervention. During that time, resident #001 began to exhibit an identified responsive behaviour which led to an altercation between residents #001 and #003.

During record review, Inspector #672 noted that resident #001 had also been involved in an incident of resident to resident abuse which occurred between residents #001 and #004 which resulted in a CIR being submitted to the Director. The CIR indicated that on a specified date, resident #001 was exhibiting a responsive behaviour which led to an altercation between residents #001 and #004 and resident #004 sustained identified injuries. Staff intervened and interventions were put in place.

Inspector #672 reviewed resident #001's progress notes during an identified time period, which indicated that prior to the incident with resident #004, resident #001 had several incidents of exhibiting an identified responsive behaviour which affected resident #004. Following one of those incidents, resident #001 continued to exhibit an identified responsive behaviour which led to negative outcomes for resident #004.

During record review, Inspector #672 reviewed a specified written plan of care for resident #004, which indicated resident #004 had been a recipient of identified incidents of resident to resident abuse with resident #001. The written plan of care further indicated interventions were supposed to have been put in place.

During multiple resident observations, Inspector #672 observed that resident #004 had identified interventions available but they were not implemented.

During an interview, resident #004 indicated the identified interventions were supposed to be implemented at all times when they were in the bedroom, to prevent resident #001 from exhibiting an identified responsive behaviour, for specified reasons.

During separate interviews, PSWs #109, #110 and RPN #111 indicated that resident #004 had identified interventions which were supposed to be implemented only upon resident #004's request.

During separate interviews, the BSO RPN, RAI Coordinator and the Administrator indicated the expectation in the home was for staff to provide care to the resident as specified in the plan. Upon review of resident #004's written plan of care, they indicated the identified interventions were supposed to be engaged at all times when resident #004 was in the bedroom, therefore resident #004's care was not provided to the resident as was specified in the plan.

The licensee failed to ensure that resident #004's care was provided to the resident as specified in the plan when staff did not engage identified interventions during multiple resident observations. [s. 6. (7)]

2. The licensee has failed to ensure that the resident's care was provided to the resident as specified in the plan.

A Critical Incident Report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #002. A second critical incident report was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #003 on a later date.

During record review, Inspector #672 noted that resident #001 had also been involved in an incident of resident to resident abuse which occurred between residents #001 and #004.

Inspector #672 reviewed resident #001's progress notes during an identified time period, which indicated the resident had multiple incidents of exhibiting multiple identified responsive behaviours which negatively affected co-residents.

Inspector #672 reviewed resident #001's current written plan of care, which indicated resident #001 was known to exhibit multiple identified responsive behaviours and had been involved in several incidents. Interventions were implemented.

During multiple resident observations for an identified time period, Inspector #672 observed that resident #001 had several identified interventions available which were not implemented.

During separate interviews, PSWs #100, #102, #109, #110 and RPNs #101, #103 and #111 indicated that staff did not utilize an identified intervention, as it was no longer required due to another identified intervention being implemented. PSWs #100, #102, #109, #110 and RPNs #101, #103 and #111 further indicated a different identified intervention was not being utilized for specified reasons.

During separate interviews, the BSO RPN, RAI Coordinator and the Administrator indicated the expectation in the home was for every resident's written plan of care to be revised immediately following any changes to the resident's care requirements and outline the resident's specified interventions and level of assistance required. The Administrator further indicated the staff members in the home were expected to provide care to each resident as outlined in the resident's plan of care. Following review of resident #001's current written plan of care, the Administrator indicated the resident was not receiving care as was outlined within the current plan.

The licensee failed to ensure that resident #001's care was provided to the resident as specified in the plan when staff did not implement identified interventions during multiple resident observations. [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 every resident's care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies developed were implemented to respond to the resident demonstrating exhibited responsive behaviours.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #002. The CIR indicated that on a specified date, resident #002 was observed to request assistance from staff as resident #001 was exhibiting a responsive behaviour which led to an altercation between residents #001 and #002. Resident #002 sustained identified injuries. A second CIR was submitted to the Director related to an incident of resident to resident abuse which occurred between residents #001 and #003. The CIR indicated that on a specified date, a staff member was to provide resident #001 with an identified intervention and the staff member went on break and did not provide the intervention. During that time, resident #001 began to exhibit an identified responsive behaviour which led to an altercation between residents #001 and #003.

Inspector #672 reviewed resident #001's current written plan of care, which indicated resident #001 was known to exhibit identified responsive behaviours and had been involved in several incidents. Interventions were implemented.

During record review, Inspector #672 reviewed resident #001's identified intervention schedule and noted that during a specified period of time, the identified intervention had only been implemented during a specified period of time. Further review of the schedule indicated there was some variability with the identified intervention schedule depending on staffing availability.

Inspector #672 reviewed resident #001's progress notes from a specified period of time, which indicated that on identified dates, the resident had multiple incidents of exhibiting identified responsive behaviours. Multiple incidents were documented to have occurred while the staff member providing an identified intervention went on break and another staff member failed to implement the intervention.

During separate interviews, PSWs #100, #102, #109, #110 and RPNs #101, #103 and #111 indicated that during the times when resident #001 did not have the identified intervention implemented, the resident would frequently exhibit multiple identified responsive behaviours which would often lead to altercations between the residents. PSWs #100, #102, #109, #110 and RPNs #101, #103 and #111 further indicated they informed the BSO and management team in the home of resident #001’s ongoing exhibited responsive behaviours when the identified intervention was not implemented, which the front-line staff struggled to manage and provide monitoring for due to time constraints on the resident home areas.

During separate interviews, the BSO RPN, RAI Coordinator, ADOC and the Administrator indicated resident #001's written plan of care did not provide clear directions to the staff regarding when the identified intervention was supposed to be implemented, for specified reasons. The Administrator further indicated the resident progress notes were reviewed daily by themselves, the ADOC or the Staff Educator, therefore had been aware of the multiple incidents which had occurred outside of the hours when the identified intervention was implemented related to resident #001 exhibiting identified responsive behaviours. The Administrator indicated the identified intervention was initially only implemented during a specified period of time for identified reasons. Lastly, the Administrator indicated the interventions from resident #001’s plan of care were not implemented according to the directions listed in order to respond to resident #001’s demonstrated responsive behaviours.

The licensee failed to ensure that the strategy developed for resident #001 was implemented, to respond to the resident’s demonstrated exhibited responsive behaviours. [s. 53. (4) (b)]

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 the strategies developed to respond to any resident demonstrating exhibited responsive behaviours are implemented, to be implemented voluntarily.

Issued on this 24th day of July, 2020

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

Original report signed by the inspector.