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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 18, 2021	2021_598570_0002	024243-20, 025231-20	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

SAMI JAROUR (570), DENISE BROWN (626)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Long-Term Care

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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

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

This inspection was conducted on the following date(s): January 13, 14, 15, 18, 19, 2021

The following intakes were inspected during this Critical Incident System inspection:
- Log #024243-20, related to allegations of abuse.
- Log #025231-20, follow up to CO #001 issued on December 15, 2020, within inspection report #2020_643111_0025, related to O. Reg. 79/10, s. 229 (4).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Infection Control Practitioner (ICP), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection, the Inspector (s) conducted a tour of the home, reviewed residents' clinical records, reviewed surveillance reports, reviewed investigation notes, and reviewed relevant policies.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2020_643111_0025	570

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents #001, #002, #003, #004, #005, #006 and #007 were protected from abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act,

Physical abuse means, under subject to subsection (2) the use of physical force by anyone other than a resident that cause physical injury or pain. O. Reg 79/10 s. 2 (1) (a).

Verbal abuse means, under subject to subsection (2) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident. O. Reg 79/10 s. 2 (1) (a).

The home submitted a Critical Incident System (CIS) report which indicated allegations of abuse toward five residents by Personal Support Worker (PSW) #105 during care.

A review of the home’s investigation notes and an interview with PSW #106 confirmed they witnessed the incidents of abuse and stated they heard abusive comments by PSW #105 toward five residents.

A review of the home’s investigation notes and an interview with RPN #108 indicated they heard PSW #105 making an inappropriate comment to a resident. The RPN indicated they spoke to PSW #105 about the inappropriateness of the comment. The RPN acknowledged they did not report the incident and that they should have.

A review of the home’s investigation notes and an interview with PSW #107 indicated that they witnessed PSW #105 was putting a resident at risk of harm during care. PSW #107 indicated they did not report the incident until spoken to by the Administrator on the following day.

The Administrator confirmed that the allegations were founded and that PSW #105 was no longer employed by the home. The Administrator acknowledged that the allegations were not immediately reported.

Source: CIS report, the home’s investigation notes. Interviews with PSW #106, PSW #107, RPN #108 and the Administrator. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of the licensee's policy "Abuse and Neglect of a Resident – Actual or Suspected" directed that:
A staff member receiving a report of or observing anyone (another staff member, volunteer, family member, visitors or resident) abusing the resident in any manner will immediately report the abuse to the DOC or designate.
Registered staff are responsible to document:
- all events related to a reported / alleged abuse in the resident chart; ensure all physical assessments/examinations, are recorded with clear descriptions and great details and entries are signed, dated with the time of documentation.
- Resident Incident Report form.

The home submitted a Critical Incident System (CIS) report which indicated allegations of abuse toward five residents by Personal Support Worker (PSW) #105 during care.

A review of progress notes for resident's involved indicated an assessment was completed upon request from the administrator for residents #002, #003 and #005.

A review of clinical records including progress notes and risk management in point click care (PCC) did not indicate any documentation that Resident Incident Report form was

completed as directed by the licensee's policy "Abuse and Neglect of a Resident – Actual or Suspected" related to the allegations of abuse toward residents #001, #002, #003, #004, #005, #006 and #007.

A review of the home's investigation notes and an interview with RPN #108 indicated they heard PSW #105 making an inappropriate comment to a resident. The RPN indicated they spoke to PSW #105 about the inappropriateness of the comment. The RPN acknowledged they did not report the incident and that they should have.

A review of the home's investigation notes and an interview with PSW #107 indicated that they witnessed PSW #105 was putting a resident at risk of harm during care. PSW #107 indicated they did not report the incident until spoken to by the Administrator on the following day.

Interview with the Director of Care (DOC) indicated the expectation is that all details of the allegations should be documented in residents' charts including the communication of the residents' substitute decision makers (SDM).

Interview with the Administrator acknowledged the allegations of abuse were not immediately reported and that residents incident reports should have been completed as per policy.

Source: CIS report, the home's investigation notes. Interviews with PSW #106, PSW #107, RPN #108, DOC and the Administrator. [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 5th day of March, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
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Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	SAMI JAROUR (570), DENISE BROWN (626)
Inspection No. / No de l’inspection :	2021_598570_0002
Log No. / No de registre :	024243-20, 025231-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 18, 2021
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, Whitby, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Strathaven 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCH Act.

Specifically, the licensee must:

1. Educate RPN #108, PSWs #106 and #107 on the licensee's policy "Abuse and Neglect of a Resident – Actual or Suspected" policy number: VII-G-10.00, revised December 2017. Test the staff knowledge of the definitions of abuse and the reporting requirement of abuse allegations and keep a documented record of the process.

Grounds / Motifs :

1. The licensee has failed to ensure residents #001, #002, #003, #004, #005, #006 and #007 were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

Physical abuse means, under subject to subsection (2) the use of physical force by anyone other than a resident that cause physical injury or pain. O. Reg 79/10 s. 2 (1) (a).

Verbal abuse means, under subject to subsection (2) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. O. Reg 79/10 s. 2 (1) (a).

The home submitted a Critical Incident System (CIS) report which indicated

allegations of abuse toward five residents by Personal Support Worker (PSW) #105 during care.

A review of the home's investigation notes and an interview with PSW #106 confirmed they witnessed the incidents of abuse and stated they heard abusive comments by PSW #105 toward five residents.

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The Administrator confirmed that the allegations were founded and that PSW #105 was no longer employed by the home. The Administrator acknowledged that the allegations were not immediately reported.

Source: CIS report, the home's investigation notes. Interviews with PSW #106, PSW #107, RPN #108 and the Administrator.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents, as multiple residents were subjected to incidents of abuse.

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Scope: The scope of this non-compliance was a pattern, as seven residents were affected by one staff member.

Compliance History: a written notification (WN) and a compliance order (CO) were previously issued under s.19. (1) in the past 36 months.
(570)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Mar 19, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sami Jarour

Service Area Office /
Bureau régional de services : Central East Service Area Office