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

Report Issue Date: September 1, 2023	
Inspection Number: 2023-1629-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Glen Hill Terrace Christian Homes Inc.	
Long Term Care Home and City: Glen Hill Terrace, Whitby	
Lead Inspector Moses Neelam (762)	**Inspector Digital Signature**
Additional Inspector(s) Natalie Jubian (000744) Miko Hawken (724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8-11 and 14-18, 2023.

The following intake(s) were inspected:

- Intakes related to resident-to-resident responsive behaviors which led to alleged abuse.
- Intakes related to alleged resident to resident abuse.
- Intake related to staff to resident neglect, and other care items.
- Intake related to an incident that led to significant change resident condition.
- Intakes related to a complaint made to the Long-Term Care Home (LTCH) related to multiple care items.
- Intakes related to complaints made regarding alleged staff to resident abuse and other care items.
- The following intakes were completed in this inspection: Intakes related to resident incidents with injury.

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

Skin and Wound Prevention and Management

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to ensure any person who has reasonable grounds to suspect abuse of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Summary and Rationale

A Critical Incident Report (CIR) was submitted to the Director related to resident-to-resident abuse.

Resident #013's electronic health records indicated that the incident occurred on a certain date.

The Director of Care (DOC) and the Director of Quality of Innovation confirmed that the incident was reported late to the Director by one day.

The failure to report the abuse to the director had minimal risk to resident.

Sources: CIR, Resident #013' s health records, DOC and Director of Quality and Innovation. [724]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (c)

The licensee has failed to ensure that, written strategies, including techniques and interventions for two residents were coordinated and implemented on an interdisciplinary basis.

Summary and Rationale

A CIR was submitted to the Director, in which there was an incident between two residents, resulting in injury.

In a separate incident on a different day, resident #001 had negative interaction with resident #006. An intervention was applied for resident #006 by the Associate Director of Care (ADOC) after this incident and was documented in both residents' progress notes. A review of residents #001 and #006's progress notes and care plan showed no mention of the intervention until approximately one month later, when there was another incident. The ADOC also indicated that it was not the expectation for Personal Support Workers (PSW's) to review the progress notes for new interventions. Furthermore, the physician referral and Behavioral Support Ontario (BSO) referral that were completed after the second incident, indicated resident #001 had a responsive behavior that required this type of intervention.

In separate interviews, multiple Personal Support Workers (PSW), indicated resident #001 regularly had the responsive behavior that could have led to the first and second incident towards other residents, including toward resident #006. The BSO Nurse, indicated that they were unaware that resident #001 had this type of behavior. Registered Practical Nurse (RPN) #110 indicated the new intervention was not applied at the time of the second incident and was unaware of the first incident.

The BSO Nurse and RPN #110 confirmed the intervention could have prevented the first and the second incident.

As a result of the lack of collaboration/coordination, the resident #001 sustained an injury.

Sources: Residents #001 and #006's care plan, progress notes, physician and BSO referrals, Interviews with BSO nurse, RPNs, PSWs. [762]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure resident #001 was protected from physical abuse by resident #006.

O.Reg., 246/22, defines Physical abuse as the following:

"physical abuse" means, subject to subsection (2),

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique")

Summary and Rationale

A CIR was submitted to the Director, in which there was an incident between two residents, resulting in injury.

Review of residents' progress notes indicated, resident #006 had a specific responsive behavior towards resident #001, leading to an injury.

In a separate incident on a different day, resident #001 had negative interaction with resident #006. An intervention was applied for resident #006 by the Associate Director of Care (ADOC) after this incident and was documented in both residents' progress notes. A review of residents #001 and #006's progress notes and care plan did not mention the intervention until a second incident. Multiple assessments completed after the incident indicated that resident #001 had multiple injuries as a result of the incident.

In separate interviews, multiple Personal Support Workers (PSW), indicated resident #001 regularly had the responsive behavior that could have led to the first and second incident towards other residents, including resident #006. Interview with RPN #118 indicated force was used towards resident #001 during this incident. The ADOC and RPN #118 confirmed this would meet the definition of physical abuse as per the Long-Term are Home (LTCH) policy.

As a result of the incident, the resident #001 was physically injured.

Sources: Resident #001 and 006's care plan and progress notes, physician and BSO referrals, and Interviews with BSO nurse, RPN #110, PSWs #112 and #113. [762]