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

Original Public Report

Report Issue Date: December 12,2023	
Inspection Number: 2023-1629-0004	
Inspection Type: Complaint	
Licensee: Glen Hill Terrace Christian Homes Inc.	
Long Term Care Home and City: Glen Hill Terrace, Whitby	
Lead Inspector Rita Lajoie (741754)	**Inspector Digital Signature** Rita Lajoie Digitally signed by Rita Lajoie Date: 2023.12.19 13:28:49 -05'00'
Additional Inspector(s) Rexel Cacayurin (741749)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30-31, 2023, November 1- 3, 6-10, 14-15, 2023.

The following intake was inspected:

- A complaint related to wound care and an allegation of neglect.

Note: Compliance order related to FLTCA, 2021, s. 24 (1) and O. Reg. 246/22, s. 55 (2) (d) were identified in a concurrent inspection #2023-1629-0005 and issued in this report.

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

Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary

A complaint was received by the Director from a resident's Substitute Decision Maker (SDM) for care regarding wound care.

Review of the clinical records including wound assessment indicated that an RPN (Registered Practical Nurse) changed a resident's wound dressing . Wound deterioration was noted and documented. RPN did not notify the Registered Nurse (RN), physician or wound care lead that the wound was deteriorating.

The Skin Care Coordinator/Resource Nurse, indicated that if a dressing is changed and it is noted that the wound is not improving or is getting worse staff are to notify the wound care lead, RN or physician.

The Assistant Director of Care (ADOC) confirmed that when a wound is noted to be deteriorating that there should be follow up with a physician, dietician, and possibly physiotherapy.

The Director of Care (DOC) confirmed that resident's wound status was assessed as deteriorating and that there was no referral made to the physician, supervisor, RN or the skin and wound lead.

Failure to communicate wound deterioration to the RN, the physician or the wound care lead may have contributed to the resident's wound not receiving appropriate treatment and care.

Sources: Interviews with RPNs, DOC, ADOC, investigating coroner, resident's progress notes, assessments, Skin and Wound Care Management Protocol (Policy: VII-G-20.10 – current revision: Feb. 2023). [741754]

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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

The licensee shall:

1. Provide in person education to all registered and direct care staff who work on a specified RHA on the Resident's Bill of Rights emphasizing rights #5, #16 and #20. The education shall incorporate scenarios of neglect and ways to protect residents from neglect relating to providing care, services and treatment consistent with resident's assessed needs. A documented record must be kept of the education provided, who attended and who delivered the education. This record is to be made available to the Inspector immediately upon request.

2. Educate all registered staff who work on the specified RHA on the home's expectations that define who is responsible for updating a resident's care plan, including when and how it is to be updated. A documented record must be kept of the education provided, who attended and who delivered the education. This record is to be made available to the Inspector immediately upon request.

3. Designate an RN or nursing management lead to conduct audits weekly on the specified RHA for a minimum of four weeks. An audit will be conducted for residents with identified wounds (existing and new) to verify that all appropriate referrals have been made, assessments have been completed and care requirements e.g. turning and positioning, heel boots, devices are being provided as ordered. The audit records must include who is conducting the audit, date, time, identification of any deficiencies, the staff member responsible and the corrective action taken to ensure staff are aware of the deficiency. Retain the audits and ensure that they are immediately available to the Inspector upon request.

Grounds

The licensee has failed to ensure that a resident was protected from neglect by staff through a pattern of inaction that jeopardized their health, safety or well-being.

Rationale and Summary

1)A complaint was received by the director from resident’s Substitute Decision Maker (SDM) for care regarding wound care.

The Residential Assessment Instrument (RAI) coordinator, confirmed that turning and repositioning appeared in resident's written plan of care.

The Point of Care (POC) task list documenting care tasks for three specified consecutive months demonstrated that resident was to be turned every two hours. Documentation indicating that this task was completed was not evident.

A review of the resident's clinical assessments demonstrated that weekly skin and wound assessments for resident's wound for which dressings were being completed every three days, were not completed for specific weeks.

The DOC confirmed that weekly skin assessments for the resident were not completed.

RPN documented in the weekly wound assessment tool that the resident's wound was deteriorating. There were no notifications made to the wound care nurse, the RN or the physician on specified dates.

The DOC confirmed that the resident's wound status was assessed as deteriorating and that there was no referral made to the physician, supervisor, RN or the skin and wound lead.

The DOC confirmed that given a pattern of inaction related to wound assessments not being completed on a weekly basis, no follow up when the wound was assessed as deteriorating on two occasions and the lack of turning and repositioning, the situation involving resident would constitute neglect.

The licensee has failed to ensure the resident was provided with the treatment, care, services or assistance required for health through a pattern of inaction that jeopardized the health, safety or well-being of the resident.

Sources: Interviews with RPN, DOC, resident's progress notes, POC task list documentation, assessments. [741754]

2) The licensee has failed to provide resident with the care or assistance required for health through inaction that jeopardized their health or well-being.

Rationale and Summary

A complaint was received by the Director from resident's SDM regarding lack of care and concerns that the resident was not turned every two hours.

An RPN confirmed that resident's written plan of care and Kardex indicated that they were to be turned and repositioned every two hours. This had been in place from the time of admission.

Review of the Point of Care (POC) task list specific to the task of turning and repositioning every two

hours demonstrated that resident was not turned every two hours from the time of admission to the home until seventeen days later.

Potential for Skin Breakdown Risk Assessment completed upon admission indicated that resident had a score of 9 (score of 6 or greater requires initiation of individualized skin care protocols or actual skin breakdown).

A new pressure ulcer was identified. A TRC Wound Assessment completed on that date indicates that the pressure injury was a new wound and that the wound was internally acquired.

Failure to provide resident with the care or assistance required through inaction resulted in an alteration of skin integrity.

Sources: Interview with RPN, resident's progress notes, care plan, Kardex, POC documentation, assessments, Treatment Administration Record (TAR).[741754]

This order must be complied with by March 8, 2024

COMPLIANCE ORDER CO #002 Skin and wound care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

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

The licensee shall:

1.Review the home's Skin and Wound Care Management Protocol with all registered staff on the second floor North wing RHA. Keep a documented record of this review including, date, time and name of staff who reviewed the document and made available to the Inspector immediately upon request.

2. Educate all registered staff on the home’s a) requirements for using the Skin and Wound Care app in Point Click Care for documenting wound assessments weekly b) requirement to follow up appropriately if a wound is noted to be deteriorating, including documentation re: who was notified e.g. Skin Care Coordinator/Resource Nurse, RN, physician, and when they were notified.

3. Designate an RN or nursing management lead with advanced wound care knowledge, to conduct audits of the MAR/ TAR and Skin and Wound app in Point Click Care weekly to verify that a) weekly wound assessments are designated to be completed on a specific day each week and b) they are completed. Conduct this audit for a period of four weeks. Ensure a documented record is kept of the audits and made available to the Inspector immediately upon request.

4. Provide the Skin Care Coordinator/Resource Nurse, with access to a skin and wound care specialist who is educated and experienced with assessing wounds, providing wound care treatment, and completing documentation. The skin and wound care specialist is to be available in person as required weekly, or when a resident's wounds are deteriorating.

5. Designate a backup person with advanced wound care knowledge and ensure they are available and on-site when the lead is not to monitor all resident wounds.

6. Ensure a documented record is kept pertaining to parts 2 and 3 of this order including the name of the individual who provided the education, the specific content of the education/ re-education, the date it was provided and the names of the staff who attended. Provide the education records to the Inspector immediately upon request.

Grounds

The licensee has failed to ensure that resident's wound was assessed weekly.

Rationale and Summary

A complaint was received by the director from resident's Substitute Decision Maker (SDM) for care regarding wound care.

A resident was admitted to the home with a documented pressure ulcer. The physician's orders at that time included dressing changes to the wound every three days.

The home's Skin and Wound Care Management Protocol specifies under 'Procedures' re: Registered Staff - 5. 'All resident wounds will be assessed weekly and as needed. Registered staff will document assessment finding and the resident's response to treatment.'

Review of the resident's progress notes indicated that the size of the wound increased from the time of admission.

A review of the resident's assessments demonstrated that wound assessments were not completed in specified consecutive weeks.

The Director of Care confirmed that the wound assessments were not completed.

Failing to ensure that the wound was assessed weekly impacted wound healing and ensuring that the wound was being treated appropriately and according to updated assessments.

Sources: Interviews with DOC, ADOC, Investigating Coroner, RPN, Skin and Wound Care Management Protocol (Policy: VII-G-20.10 – current revision: Feb. 2023), resident's progress notes, MAR, TAR, assessments.[741754]

This order must be complied with by March 8, 2024

COMPLIANCE ORDER CO #003 Skin and wound care program

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

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

The licensee shall:

1.The Skin Care Coordinator/Resource Nurse, with the support of the Skin and Wound Care committee, shall create a turning and positioning program that describes the key principles of positioning, explains why turning and positioning is important and provides specific responsibilities and expectations for all staff regarding turning and positioning e.g. frequency, schedules, documentation requirements to capture the intervention, etc.

2. Educate all registered staff and direct care staff on the turning and positioning program created in requirement 1. of this order.

3. Maintain a written record of training provided to all registered nursing staff and direct care staff that includes who attended the training, the content, and the date the training was completed.

4. Designate an RN or nursing management lead to conduct a) care plan audits once weekly to ensure that orders for turning and positioning are updated in the care plan and align with orders in the Kardex and b) weekly audits of Point of Care documentation to ensure that turning and positioning was documented as per orders in the care plan / Kardex. Conduct this audit for a period of four weeks

5. The date of the audits, the person responsible, and the results of the audit must be documented. Analyze the results of the audits to identify any gaps or omissions, action is taken, and the results of the action are documented. Retain the audits and ensure that they are immediately available to the Inspector upon request.

Grounds
The licensee has failed to ensure that resident was turned and repositioned every two hours.

Rationale and Summary

1) A complaint was received by the Director to the Action Line from a resident's SDM for care regarding wound care.

A review of the resident's assessments upon admission indicated that they had risk factors for skin breakdown related to an existing wound, cognitive status, hydration status, their ability to move in bed and turn themselves.

An RPN confirmed that turning and repositioning appeared in the resident's written plan of care on a specified date but was not initiated as a task in POC .

A review of the resident's care plans and Kardex indicated that the resident was in the turning and repositioning program.

The POC task list documenting care tasks for specified months demonstrated that the resident was not turned and repositioned every two hours as required.

Failure to ensure that the resident was turned and repositioned every two hours may have compromised wound healing.

Sources: Interviews with RPNs, DOC, resident's care plans, Kardex, POC task documentation, assessments, progress notes, Skin and Wound Care Management Protocol (Policy: VII-G-20.10 – current revision: Feb. 2023).[741754]

2)The licensee has failed to ensure that resident was turned and repositioned every two hours as required by their condition.

Rationale and Summary

A complaint was received by the Director from resident's SDM regarding lack of care and concerns that the resident was not turned every two hours.

Review of the POC documentation with an RPN confirmed that turning and repositioning every two hours was specified in resident's written plan of care and on their Kardex, from the time of admission. RPN confirmed that turning and repositioning every two hours was not completed from the time of admission until seventeen days later.

Review of the POC task list specific to the task of turning and repositioning every two hours demonstrated that resident was not turned every two hours from the time of admission to the home until seventeen days later.

Assessments completed upon admission indicated that the resident did not have any wounds at the time they were admitted to the home. A new wound was identified seventeen days later.

Failure to turn and reposition resident every two hours put them at risk for developing skin breakdown.

Sources: Interviews with RPNs, resident's progress notes, POC documentation, care plan, Kardex. [741754]

This order must be complied with by March 8, 2024

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.