Ontario



**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

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| **Report Issue Date: February 29, 2024** | |
| **Inspection Number:** 2024-1629-0002 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** Glen Hill Terrace Christian Homes Inc. | |
| **Long Term Care Home and City:** Glen Hill Terrace, Whitby | |
| **Lead Inspector**<br>Julie Dunn (706026) | **Inspector Digital Signature** |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 29 - 31, 2024

The following critical incident(s) were inspected:

- Intake: #00106562 - related to a resident to resident altercation.

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

Responsive Behaviours
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Altercations and other interactions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 59**
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

Following a resident-to-resident altercation, the licensee failed to ensure that steps were taken to minimize the risk of further altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and observation, that could potentially trigger such altercations; and identifying and implementing interventions.

**Rationale and Summary**

A critical incident report was submitted to the Director, reporting an alleged resident to resident altercation that resulted in a change in health status for one of the residents.

A progress note and a phone call to the Ministry's after-hours line both provided details of the resident-to-resident altercation.

Review of video footage showed the sequence of events of the resident-to-resident altercation.

Two Registered Practical Nurses (RPNs) confirmed that there was a new behaviour for one of the residents.

An RPN indicated that there was no Behaviour Support Ontario (BSO) Lead in the home and they were unsure how long the home had been without a BSO Lead. They indicated that virtual BSO consultations were available. The RPN indicated that it was an expectation that a referral would be made if a resident had a new identified behaviour or if there was a resident-to-resident altercation. The RPN indicated that there would be a care plan update with new interventions generated. The RPN confirmed that the care plan for the resident had not been updated after the new behaviour was identified and they were not sure if a referral had been made.

A progress note for the resident indicated that a specific intervention was implemented, however the intervention was not documented in the care plan for the resident.  Review of the care plan did not indicate there was any review or reassessment to identify potential triggers., nor any update with new interventions

to manage the newly identified responsive behaviour after the resident-to-resident altercation.

Failing to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and observation, that could potentially trigger such altercations; and identifying and implementing interventions, increased the risk for subsequent resident-to-resident altercations.

**Sources:** Clinical records for residents, video footage provided by the LTC home, interviews with staff.
[706026]

## WRITTEN NOTIFICATION: Behaviours and altercations

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 60 (b)**
Behaviours and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others.

Non-compliance with O. Reg. 246/22 s. 60. (b)
The licensee failed to ensure that all direct care staff for a resident were advised at the beginning of every shift of the resident's responsive behaviours that required heightened monitoring because those behaviours posed a potential risk to the resident or others.

**Rationale and Summary**
A critical incident report was submitted to the Director, reporting an alleged resident-to-resident altercation that resulted in a change in health status for one of the residents.

Review of video footage showed the sequence of events of the resident-to-resident altercation.

A progress note indicated a specific intervention was implemented for a resident.

During observations on two different days, direct care staff indicated they were not advised at the beginning of their shift of the resident's responsive behaviours that required heightened monitoring.

A document that outlined the care needs for the resident did not provide information for the direct care staff about the resident's responsive behaviours that required monitoring because those behaviours posed a potential risk to the resident or others..

An RPN indicated they were not sure if there were instructions for the direct care staff providing care for the resident.

Failing to ensure that all direct care staff for the resident were advised of responsive behaviours that required heightened monitoring, posed a potential risk to the resident or co-residents.

**Sources**: Video footage provided by LTC home, clinical records, observations and interviews with staff.
[706026]

## COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: FLTCA, 2021, s. 25 (1)**
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
The licensee shall:
a) Designate a nursing management lead to provide in-person training to all registered and direct care staff, including agency staff, who work in a specific home area, on the LTC home's policy to promote zero tolerance of abuse, including the section titled, “When the Abuser is Another Resident”, responsive behaviours and resident-to-resident altercations, and on strategies to support residents with responsive behaviours and mitigate risks.

b) Administer a supervised test to all staff post training. Ensure all staff complete the test independently and without aid. Ensure that any staff receiving a final grade of less than 80% on the test are provided with retraining and are retested on the materials. Maintain a documented record of the test materials, the administration record, and the final grades for each participant as well as the date the test was administered, to be made available to the Inspector immediately upon request.

c) Keep a record of all training, including the dates of the training, who provided the training, and the content of the training provided. This record is to be made available to the Inspector immediately upon request.

d) As indicated in the LTC home's policy to promote zero tolerance of abuse, implement timely and appropriate referrals for the resident, including referral to a BSO nurse. Use standardized tools, such as the Dementia Observation System (DOS) tool to ensure appropriate monitoring, assessments and analysis for the resident, in order to identify specific care needs, potential triggers for responsive behaviours, and to develop resident-specific care plan interventions as appropriate for supporting the resident and preventing resident-to-resident altercations. Keep a record of the referrals, monitoring, assessments and analysis and results for the resident. This record is to be made available to the Inspector immediately upon request.

e) Designate a nursing management lead to develop and implement an auditing system to audit and verify for a period of three weeks that registered and direct care staff who provide care and support for the resident are advised at the beginning of every shift, of the resident's care needs, responsive behaviours, and potential triggers that require heightened monitoring. Keep record of the audits, including the name of staff audited, the staff conducting the audit, date and time of the audits and any corrective actions made as a result of analyzing the audit results. This record is to be made available to the Inspector immediately upon request.

**Grounds**
Non-compliance with: FLTCA, 2021, s. 25 (1)
The licensee failed to ensure compliance with their written policy to promote zero tolerance of abuse and neglect of residents.

**Rationale and Summary:**
Section 2. (1) (c) of the Ontario Regulation 246/22 defines “physical abuse” as the use of physical force by a resident that causes physical injury to another resident.

A critical incident report was submitted to the Director, reporting an alleged resident-to-resident altercation that resulted in a resident’s change in health status.

Review of video footage provided by the LTC home showed the sequence of events of the resident-to-resident altercation.

The LTC home’s policy, Abuse and Neglect – Zero Tolerance Policy, included a definition for physical abuse, including the use of physical force by a resident that causes physical injury to another resident. In an interview, an RPN confirmed that the incident met the definition of resident-to-resident abuse.

The LTC home’s policy, Abuse and Neglect – Zero Tolerance Policy, included a section titled, “When the Abuser is Another Resident”. The section provided five steps to be taken, including assessment of the resident’s needs, identifying potential triggers, and referrals for physician, pharmacological, BSO, psychogeriatric and counselling services, as appropriate.

In an interview, an RPN indicated that it was an expectation that a referral would be made if there was a resident-to-resident altercation, and that there would be a care plan update with new interventions generated. The RPN confirmed that the care plan for the resident had not been updated, and they were unsure if any referral was made.

Review of the care plan for the resident showed there was no review or reassessment documented to identify potential triggers, nor any new interventions

to manage the newly identified responsive behaviour.

Failure to ensure compliance with the licensee's written policy, Abuse and Neglect – Zero Tolerance Policy, resulted in a resident-to-resident altercation and jeopardized the health, safety and well-being of a resident.

Failure to ensure compliance with the licensee's written policy to promote zero tolerance of abuse, including timely and appropriate assessment and referral to support a resident, following the resident-to-resident altercation, increased the risk to the health and well-being of other co-residents.

**Sources:** Clinical records, LTC home's policy Abuse and Neglect – Zero Tolerance Policy, video footage provided by the LTC home, interview with staff.
[706026]

**This order must be complied with by** May 17, 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.