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
Jul 15, 2021	2021_718535_0009	002164-21, 002175-21, 005302-21, 006965-21, 006969-21, 006978-21	Critical Incident System

Licensee/Titulaire de permis

ATK Care Inc.
1386 Indian Grove Mississauga ON L5H 2S6

Long-Term Care Home/Foyer de soins de longue durée

River Glen Haven Nursing Home
160 High Street P.O. Box 368 Sutton West ON L0E 1R0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

VERON ASH (535)

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): June 8, 9, 11, 14, 15, 16, 2021.

The following intakes were completed during this inspection:

Log #005302-21- was related to falls,
Log #002164-21- was related to neglect,
Log #006978-21, #006965-21, #002175-21, #006965-21 and #006969-21 were related to abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Maintenance Manager, Physiotherapist (PT), Physiotherapy Assistant (PA), Scheduler, registered staff (RN/RPN), personal support workers (PSW), personal care associate (PCA) and entrance screener (ES).

During the course of the inspection, the inspector conducted observations at the entrance of the home, resident home areas and staff to resident interactions, reviewed clinical health records, staffing schedule, internal investigation records, staff education and personnel records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
1 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. 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 that the resident was protected from emotional abuse by staff in the home.

For the purposes of the definition of abuse in subsection 2 (1) of the Regulation, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

The resident’s one to one PSW required assistance and a second PSW attended the room to provide support. The second PSW used their arm/forearm to prevent the resident's movement instead of explaining to the resident what was required and why they needed to remain in place.

Later that same shift, the one to one PSW requested help with the resident's care and an RPN attended the room to help with the care. The RPN used inappropriate actions and belittling statements when providing the resident's care.

The home's investigation notes indicated that the resident was negatively affected by the RPN's statements.

Sources: CIS report, interviews with PSWs, DOC and others. [s. 19. (1)]

2. The licensee has failed to ensure that the resident was free from neglect by a PSW.

Section 5 of the Regulation defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including

inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

The resident's one to one PSW requested assistance from a third PSW to provide personal care. The third PSW entered the room and proceeded to use an inappropriate method of getting the resident's attention, helped with only a small portion of the care, then left the room without completing the resident's personal care.

The one to one PSW provided the resident's care, although they were not assigned to provide direct care to the resident. They reported the incident to the home's management.

The DOC verified that the third PSW was disciplined, provided with additional education and relocated to another home area to protect the resident.

Sources : CIS report, resident’s electronic documentation records, interview with PSWs, DOC and others. [s. 19. (1)]

3. For the purposes of the definition of abuse in subsection 2 (1) of the Regulation, verbal abuse means, 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.

On an identified date, a PSW observed and heard a second PSW belittled the resident by imitating their vocal challenges while responding to the resident's questions. The resident's written care plan listed multiple recommendations how to communicate with the resident, however the second PSW did not engage with the resident by implementing those recommendations.

The DOC verified that they provided additional education to the second PSW related to the incident.

Sources: CIS report, home’s investigation notes, resident’s profile, MDS and progress notes, interview with PSWs, DOC and others. [s. 19. (1)]

4. The licensee has failed to ensure that the resident was protected from physical abuse and neglect by staff in the home.

For the purposes of the definition of abuse in subsection 2 of the Regulation, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident required personal care, and their written care plan stated two staff to perform personal care. On an identified date, four PSWs entered the resident's room and three PSWs performed personal care to the resident. One PSW observed that the resident was experiencing pain and informed the other three PSWs that the resident was having pain. However, they continued providing the personal care in the same manner. They also did not inform the RPN that the resident had experienced pain and required medication to manage their pain.

The DOC verified the results of their investigation, and stated that all PSWs involved were provided additional education, separated and relocated to other home areas ensure the resident's safety.

Sources : CIS report, resident’s care plan, interview with PSWs, DOC and others. [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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to the resident as specified.

The resident was assessed to have responsive behaviors. A review of their written care plan indicated that one to one PSW was required to support behavior management.

The resident was assigned a one to one PSW during the shift. When the one to one PSW left the home area for a break, the resident started exhibiting responsive behaviors which were disruptive and threatened the safety of other residents in the home area. The resident was not assigned a one to one PSW replacement for coverage during the break as verified by PSWs who worked the same shift.

The DOC verified that the PSW who was assigned to provide personal care for the resident during the shift, should have provided one to one coverage when the one to one PSW was on their break. They also verified that the plan of care was not provided to the resident as specified.

Sources : CIS report, resident’s written care plan, interviews with PSWs, DOC and others. [s. 6. (7)]

2. The licensee has failed to ensure the resident was reassessed and the plan of care reviewed and revised when the resident’s care needs changed.

The resident was admitted, assessed and experienced a fall incident on the same day. They were assigned a one to one PSW since they had refused to remain in their room on isolation as required. The resident was walking with an unsteady gait and the Phyiotherapy Assistant provided a mobility device to support ambulation. However, the physiotherapist was not available to assess the resident prior to them being assigned and using a mobility device. The resident refused to use the device, and eventually tripped over the device and fell to the floor. They were transferred to the hospital where they were diagnosed with an injury and had a scheduled procedure.

PT #105 verified that the resident’s mobility status should have been reassessed by a physiotherapist prior to providing the mobility device for use.

Source: CIS report, resident’s MDS and progress notes, interviews with PT, RPN, PSW and others. [s. 6. (10) (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 that the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

A review of the home's temperature logs indicated that residents' room temperature were not being measured and documented. The home’s Maintenance Manager verified that the air temperature was measured in common areas in the home; however they did not measure and document in writing the air temperature in two resident bedrooms in different parts of the home, as required by the Regulation.

Sources : Air Temperature logs, interview with Maintenance Manager and others. [s. 21. (2) 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 temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to the resident, that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

The resident sustained a fall, and was transferred to hospital. They were diagnosed with an injury for which they had a scheduled procedure. The resident's progress notes indicated that the home was notified of the resident's injury and scheduled procedure days before the home submitted the critical incident to the Director.

The Director of Care (DOC) acknowledged that the incident should have been reported as soon as the home was notified of the resident's injury.

Sources: CIS report, resident's progress notes, interview with DOC and others. [s. 107. (3)]

Issued on this 16th day of July, 2021

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

Original report signed by the inspector.