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: December 11, 2023	
Inspection Number: 2023-1022-0005	
Inspection Type: Critical Incident	
Licensee: ATK Care Inc.	
Long Term Care Home and City: River Glen Haven Nursing Home, Sutton West	
Lead Inspector Vernon Abellera (741751)	**Inspector Digital Signature** Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2023.12.18 09:48:21 -05'00'
Additional Inspector(s) Jovairia Awan (648)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14 to 17, 21 to 23, 2023.

The following intake(s) were inspected:
*One intake related to alleged resident-to-resident abuse.
*The following intakes were completed in this inspection: Intakes related to resident's fall with injury.

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

Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard 6.1

1) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

In accordance with the IPAC Standard for Long Term Care Homes April 2022 (IPAC Standard) section 6.1 states, the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include having a PPE supply and stewardship plan in place and ensuring adequate access to PPE for Routine Practices and Additional Precautions. The licensee shall ensure that the PPE supply and stewardship plan is consistent with any relevant Directives and/or Guidance, regarding appropriate PPE use, from the Chief Medical Officer of Health or the Minister of Long-Term Care, which may be in place.

Rationale and Summary:

Inspector #741751 conducted the IPAC tour. Residents in several rooms were on additional precaution and staff, and visitors were required to wear specific PPE, as indicated by the signage posted on their doors. The PPE supply was not available and accessible to staff; the PPE bin on the wall outside the rooms were empty.

The Building Summary report identified several residents in multiple rooms who were diagnosed with an infection.

The IPAC lead confirmed that residents on additional precautions should have enough PPE in the supply bins and were to be refilled once the supply was insufficient.

Failure to make PPE available and accessible to staff and residents for additional precautions may have increased risk of transmission to both residents and staff.

Sources: Observations, Interview with IPAC lead. [741751]

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b), IPAC Standard 9.1 (f)

2) The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee failed to ensure that additional PPE requirements including appropriate selection, application, removal, and disposal, were followed in the IPAC program as required by Additional Requirement 9.1 Additional Precautions (f) under the IPAC Standard.

Rationale and Summary:

Inspector #741751 conducted the IPAC tour. A Personal Support Worker (PSW) was in a resident's room, which was on additional precautions and was required to don specific PPE. The PSW was observed not wearing the appropriate PPE while providing care to a resident, as required by the PPE signage posted on the door.

The Building Summary report identified the resident as currently under additional precaution.

The PSW confirmed that they failed to use the appropriate PPE when assisting the resident with care at the time of the observation.

The IPAC lead confirmed that the staff member should follow the additional precautions sign and wear the appropriate PPE when providing care for the resident.

Failure to apply the appropriate PPE during enhanced precaution for residents increased the risk for the spread of infection in the home.

Sources: Observations, The building summary report, Interviews with the PSW and IPAC lead [741751]