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: April 25, 2024

Inspection Number: 2024-1022-0001

Inspection Type:
Complaint
Critical Incident

Licensee: ATK Care Inc.

Long Term Care Home and City: River Glen Haven Nursing Home, Sutton West

Lead Inspector	**Inspector Digital Signature**
Vernon Abellera (741751)	Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2024.05.13 06:43:58 -04'00'

Additional Inspector(s)
Iqbal Kalsi (743139)
Moses Neelam (762) was present for the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19-22, 25-26, 2024.

The following intake(s) were inspected:

- One Intake related to alleged physical abuse.
- One complaint Intake related to hot water supply.
- One intake related to environmental hazard.Two intakes related to an outbreak.

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

Housekeeping, Laundry and Maintenance Services

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (b)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(b) is on at all times;

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that on at all times, specifically on the first floor bath/tub room.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director indicating that call bell system was not working for a certain period. Inspector #743139 and Training Specialist #762 observed the call bell system on the first floor was not working. Registered Practical Nurse (RPN) confirmed that the call bell was not working and that two staff would

always be present during the resident bath and shower. Subsequent observation by Inspector #743139 and Inspector# 741751, the call bell was working. The Administrator confirmed that the call bell system was repaired as a result and the risk to the residents was minimal.

Sources: Observations, interview with Administrator and RPN #110 [743139]

Date Remedy Implemented: March 20, 2024

WRITTEN NOTIFICATION: Maintenance services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

The licensee failed to ensure that procedures for call bell maintenance are implemented to ensure that all equipment, in the home are kept in good repair,

Rationale and Summary

A CI was submitted to the Director indicating that call bell system was not working The LTCH Call Bell Policy which indicated that audits are to be completed monthly for the following: Check that all call cords are in place, check for system audibility, replace defective components as necessary and check the function of the following: Lamps, Control panel Remote panel(s), Corridor display panels, Dome

lamps, Zone lamps, Initiating devices, Audible devices. In addition, maintenance logs were reviewed on a certain period, and no call system information as per Call bell policy was included. The management meeting minutes indicated that the documentation for call bell systems as required by the policy was not being followed. The Administrator confirmed that the policy was not being implemented in an interview.

The risk was minimal as the Administrator indicated that checks being done informally.

Sources: Call bell Policy, maintenance logs and interview with the administrator [743139]

WRITTEN NOTIFICATION: Hazardous substances

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee has failed to ensure that that all hazardous substances at the home are kept inaccessible to residents at all times.

Rationale and Summary

Inspector #741751 observed that the door of a shower room was unlocked and left open without any staff supervision. The shower rooms was all stocked with

disinfectant, shampoo, briefs, and other personal care supplies inside and accessible.

The incident occurred when the two contractors assigned to fix the call bell in the first-floor shower room left the door open to see the other area on the second floor.

Registered Nurse (RN) confirmed that the shower rooms should be always closed when unattended. RN initiated closing the shower room door.

Personal Support Worker (PSW) indicated that there was a risk of ingestion of hazardous materials if the door was left unattended.

The Director of Environmental Services (DES) spoke with the contractor and stated that there was a risk to residents when shower rooms stocked with personal items were not locked and hazardous items were accessible to residents.

As a result, the residents were at risk of entering the shower room, which contained potentially harmful substances and items.

Sources: Observations; Interviews with PSW#110 and RN #102 and DES. [741751]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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. O. Reg. 246/22, s. 102 (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 PSW was in a resident's room, which was on additional precaution and was required to don Personal Protective Equipment (PPE). The PSW was observed not wearing the appropriate PPE while providing care for resident, as required by the PPE sign posted on the door.

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

PSW confirmed that they failed to use the appropriate PPE when assisting the resident 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 PSW #109 and IPAC lead [741751]

WRITTEN NOTIFICATION: Police notification

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service was immediately notified of a witnessed incident of physical abuse of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary

A CI was reported to the Director concerning alleged unwitnessed abuse by PSW towards resident.

The incident occurred when resident exhibited responsive behavior while having a shower. PSW promptly initiated a code white to de-escalate the situation. An injury was observed on the resident's upper extremities, and it was alleged that PSW is the cause of the injury. There was no record indicating that the police services were contacted.

The Administrator confirmed that the police was not called when they became

aware of the incident.

Failure to ensure the appropriate police service was notified upon alleged abuse, could potentially increase the risk of recurrence at the home.

Sources: Resident's electronic medical records, Investigation notes, CI , and interview with Administrator. [741751]