



Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Jul 12, 13, 16, 17, 18, 19, 23, 2012; 2012\_078202\_0019; Complaint

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

VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Environmental Services Manager, Registered Staff, Personal Support Workers

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, observed resident washroom equipment, home's policies related to Pain Management, Falls Prevention and Management

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Falls Prevention

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legende
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 15. Accommodation services  
Specifically failed to comply with the following subsections:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**  
**(a) the home, furnishings and equipment are kept clean and sanitary;**  
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and**  
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that equipment used in the home is maintained in a safe condition. [s.15.(2)(c)]

On September 26, 2011 at 1135 hours resident A sustained compression fractures to vertebrae T12 and L2 when the raised toilet seat that was in use in the washroom shifted causing resident A to fall on the floor.

Resident A's plan of care identifies this resident to toilet independently using a raised toilet seat and requiring minimal staff assistance.

The Environmental Services Manager (ESM) indicated in an interview that toilets in the home have been newly replaced and that the raised toilet seats used in the home do not always fit the toilet bowl properly.

Registered staff interviews confirmed that there is no system in place to determine the actual use and fit of raised toilet seats used in the home and that it is the responsibility of direct care staff to ensure that all raised toilet seats are attached secure to the toilet prior to resident use.

Staff interviews confirmed that the raised toilet seat used by resident A had not been fastened securely to the toilet prior to use on September 26, 2011.[s.15.(2)(c)]

Resident rooms were observed on July 18, 2012 by inspector which identified loose fitting raised toilet seats in 6 rooms on an identified resident home area.[s.15.(2)(c)]

**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 O.Reg 79/10, s. 107. Reports re critical incidents**

Specifically failed to comply with the following subsections:

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.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
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).

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the Director is informed of an incident no later than one business day after an injury in respect of which a person is taken to hospital.[s.107.(3)4]

Resident A fell on September 26, 2012 in bedroom washroom and was transferred to hospital for further assessment on September 28, 2012 due to severe back pain. Resident A returned to the home on September 29, 2012 with a diagnosis of compression fractures at T12 and L2.

Resident B fell on March 22, 2012 at 10:00 hours and sustained a large hematoma to left occipital area and skin tear to left elbow. Resident B was sent to hospital for further assessment on March 23, 2012 at 1800 hours.

The Director of Care confirmed in an interview that the Director was not informed of the above incidents resulting in injury in respect to which resident's A and B were taken to hospital.[s.107.(3)4]

**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 Director is informed of an incident no later than one business day after an injury in respect of which a person is taken to hospital, to be implemented voluntarily.*

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**WN #3: 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 subsections:

- s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
- (a) the planned care for the resident;
  - (b) the goals the care is intended to achieve; and
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide care to the resident. [s.6 (1) (c)]

Staff interviews revealed that resident's A, B and C are to use a raised toilet seat for toileting.

Clinical record review confirmed that the written plan of care for resident's A, B and C does not include use of a raised toilet seat for toileting.



Ministry of Health and  
Long-Term Care

Inspection Report under  
the Long-Term Care  
Homes Act, 2007

Ministère de la Santé et des  
Soins de longue durée

Rapport d'inspection  
prévus le Loi de 2007 les  
foyers de soins de longue

Issued on this 23rd day of July, 2012

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

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the right.



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

**Ordre(s) de l'inspecteur**  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

**Health System Accountability and Performance Division  
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé  
Direction de l'amélioration de la performance et de la conformité**

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<b>Name of Inspector (ID #) / Nom de l'inspecteur (No) :</b>	VALERIE JOHNSTON (202)
<b>Inspection No. / No de l'inspection :</b>	2012_078202_0019
<b>Type of Inspection / Genre d'inspection:</b>	Complaint
<b>Date of Inspection / Date de l'inspection :</b>	Jul 12, 13, 16, 17, 18, 19, 23, 2012
<b>Licensee / Titulaire de permis :</b>	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
<b>LTC Home / Foyer de SLD :</b>	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
<b>Name of Administrator / Nom de l'administratrice ou de l'administrateur :</b>	KAREN RYAN

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To ATK CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et  
des Soins de longue durée**

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

**Ordre(s) de l'inspecteur**  
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de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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**Order # /**  
**Ordre no :** 001      **Order Type /**  
**Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,  
(a) the home, furnishings and equipment are kept clean and sanitary;  
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and  
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan to ensure that that the raised toilet seats used by residents in the home are maintained in a safe condition. Please submit plan to [valerie.johnston@ontario.ca](mailto:valerie.johnston@ontario.ca) by August 03, 2012.

**Grounds / Motifs :**

1. The licensee failed to ensure that equipment used in the home is maintained in a safe condition. [s.15.(2)(c)]

On September 26, 2011 at 1135 hours resident A sustained compression fractures to vertebrae T12 and L2 when the raised toilet seat that was in use in the washroom shifted causing resident A to fall on the floor.

Resident A's plan of care identifies this resident to toilet independently using a raised toilet seat and requiring minimal staff assistance.

The Environmental Services Manager (ESM) indicated in an interview that toilets in the home have been newly replaced and that the raised toilet seats used in the home do not always fit the toilet bowl properly.

Registered staff interviews confirmed that there is no system in place to determine the actual use and fit of raised toilet seats used in the home and that it is the responsibility of direct care staff to ensure that all raised toilet seats are attached secure to the toilet prior to resident use.

Staff interviews confirmed that the raised toilet seat used by resident A had not been fastened securely to the toilet prior to use on September 26, 2011.[s.15.(2)(c)]

Resident rooms were observed on July 18, 2012 by inspector which identified loose fitting raised toilet seats in 6 rooms on an identified resident home area.[s.15.(2)(c)] (202)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :** Aug 17, 2012



Ministry of Health and  
Long-Term Care

Ministère de la Santé et  
des Soins de longue durée

Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

### REVIEW/APEAL INFORMATION

#### TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
55 St. Clair Avenue West  
Suite 800, 8th Floor  
Toronto, ON M4V 2Y2  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
55 St. Clair Avenue West  
Suite 800, 8th Floor  
Toronto, ON M4V 2Y2  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

**RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

**PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
55, avenue St. Clair Ouest  
8e étage, bureau 800  
Toronto (Ontario) M4V 2Y2  
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 23rd day of July, 2012**

**Signature of Inspector /  
Signature de l'inspecteur :**

**Name of Inspector /  
Nom de l'inspecteur :** Valerie Johnston

**Service Area Office /  
Bureau régional de services :** Toronto Service Area Office