Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 3, 2015	2015_297558_0006	T-2284-15	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

BARBARA PARISOTTO (558)

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): April 16, 30, 2015.

Throughout the inspection the inspector observed staff to resident interactions and reviewed personal health care records, training records, applicable home policies and other pertinent documentation.

During the course of the inspection, the inspector(s) spoke with the administrator, the director of care (DOC), the assistant director of care (ADOC), registered nursing staff, personal service workers (PSWs), resident and power of attorney.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **0 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	Legendé 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 residents are protected from abuse by anyone.

A review of resident #1's resident assessment instrument minimum data set (RAI MDS) on a specified date, revealed the resident had an identified diagnosis and was prescribed medication to help alleviate behaviours. The resident may become frustrated when communicating verbally to others and may curse or hit out. The resident can usually be redirected, but at times behaviours cannot be redirected and is challenging for staff. The resident can be resistive to care.

An identified critical incident report was submitted on a specified date related to an alleged incident of staff to resident abuse. A record review and staff interview revealed that resident #1 became resistive while receiving care and struck out with his/her arm at the staff member providing care. The staff member confirmed he/she grabbed the wrists of resident #1 who subsequently sustained an alteration in skin integrity. On a specified date, the inspector observed the alteration in skin integrity on resident #1.

The use of force by the staff member while providing care to resident #1 caused minor physical injury to the resident.

An interview with the DOC revealed the home's investigation concluded abuse had occurred and the staff member was suspended without pay until further notice for the incident that occurred. [s. 19. (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 that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reports the suspicion and the information upon which it was based to the Director.

On a specified date and time, an incident alleging staff to resident abuse was reported to registered staff. Staff interviews revealed the incident was documented and reported to the DOC through e-mail communication.

Interview with the DOC revealed registered staff are expected to contact the Director immediately when made aware of alleged abuse. The identified critical incident related to abuse was reported to the Director through the after hours phone number approximately 22.5 hours after the incident occurred.

The DOC confirmed the allegation of abuse was not reported immediately to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive retraining annually relating to the following:
- The Residents' Bill of Rights
- The home's policy to promote zero tolerance of abuse and neglect of residents
- The duty to make mandatory reports under section 24
- The whistle-blowing protections

A record review and staff interviews confirmed that 80.8% of nursing staff did not receive retraining relating to The Residents' Bill of Rights and 60.6% of nursing staff did not receive retraining related to abuse and related topics in 2014. [s. 76. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, is prepared.

An interview with the ADOC confirmed the home does not have a written record for the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents. [s. 99. (e)]

Issued on this 3rd day of June, 2015

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

Original report signed by the inspector.