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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700 rue Yonge 5e étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 9, 2017	2017_626501_0004	003953-17, 004324-17	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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 24, 27, 28, March 1 and 2, 2017.

This inspection is related to intake #003953-17 and #004324-17 related to duty to protect and responsive behaviours. This inspection was completed concurrently with 2017_626501_0005 and 2017_626501_0006.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Nurse from Ontario Shores, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), physicians, Behavioural Support Services/Recreation Therapist, Substitute Decision Makers (SDMs) and residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 protect resident #006 from abuse.

One type of abuse as outlined in section 2.(1) of the Regulation (O.Reg.79/10) means any non-consensual touching, behavior or remarks of an identified nature or exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified date, a complaint was received by the MOHLTC INFOLINE indicating the home is not protecting residents from the identified abuse of resident #001. On an identified date, a Registered Nurse (RN) had informed the MOHLTC that resident #001 was found in resident #006's room acting inappropriately towards him/her.

Review of an identified Critical Incident Report (CIR) revealed Personal Support Worker (PSW) #006 reported to Registered Practical Nurse (RPN) #010 that he/she witnessed resident #001 in resident #006's room acting inappropriately towards him/her. Resident #006 was sitting in his/her wheel-chair at the time. Resident #006 did not appear distressed. Mini-Mental State Examination (MMSE) for resident #001 indicated severe cognitive impairment and MMSE for resident #006 indicated severe cognitive impairment. Resident #006's Substitute Decision Maker (SDM) expressed that he/she was not upset according to the CIR.

Review of progress notes revealed resident #001 had acted inappropriately with resident #006 in the hallway on an identified date, and when the SDM was contacted he/she was noted to say that he/she was okay if someone acted in the identified manner toward his/her mother/father as long as it happens in a public area and not in his/her room. Interviews with RPN #010, PSW #005, and RN #009 revealed resident #006 often makes identified gestures to everyone and RN #009 and RN#008 confirmed resident #006 is not capable to consent to an identified activity. Interview with resident #006's SDM revealed that he/she was not concerned before but now that resident #001 has gone into his/her room he/she is worried because resident #006 could not say no.

Interview with PSW #006 revealed he/she was taking residents back to their rooms from the dining room on an identified date at about 1745 hours when he/she noticed resident #001 leaning over resident #006 and acting inappropriately in resident #006's room. The PSW indicated he/she redirected resident #001 out of resident #006's room and reported the incident to RPN #010. PSW #006 indicated that a multidisciplinary meeting took place shortly after the incident and it was discussed that resident #001 had been upset for a few days prior to this incident because someone had taken his/her personal belongings from his/her room. The team has since identified invading resident #001's space and taking his possessions are triggers for his/her inappropriate behaviours. Review of resident #001's most recent written plan of care revealed it had been updated

to include that resident #001 is to have identified belongings in the top drawer of his/her dresser and this is not to be removed.

Review of a report from Ontario Shores that was faxed to the home on an identified date, revealed several care recommendations. One of the recommendations was to consider the use of an identified type of medication. Interview with resident #001's physician revealed he/she was not made aware of this report and recommendation for medication until after the incident, which was when he/she initiated a low dose of the medication. In addition, the report recommended implementing a healthy sleeping pattern at night time and engaging him/her in tasks that make him feel as though he/she is being helpful. Review of progress notes for resident #001 revealed there was no indication that sleeping medications were being adjusted until an identified date, and engaging the resident with helpful tasks had not yet been set up as a routine.

Interview with Behaviour Support Services (BSS) staff #016 revealed he/she has just completed training for this new position and will start to implement more of the recommendations in the Ontario Shores report in an identified week. He/she indicated to the inspector that staff at the home need to refrain from judging resident #001 and reach out and engage him/her as he/she is lonely and lost. There is also another BSS staff member starting and both will be working to implement the recommendations in the Ontario Shores report involving having resident #001 engaged in a routine that will keep him/her occupied which will hopefully help to prevent recurrences of abuse.

Interview with RN #014 from the Geriatric and Neuropsychiatry Outreach Services (GNOS) from Ontario Shores revealed that he/she has been involved in resident #001's care since December 2016, and he/she had found that due to his/her dementia he/she has diminished impulse control. The RN told the inspector that certain things trigger resident #001 such as staff taking his/her belongings. He/she indicated the home needed to work on being more collaborative with his/her plan of care and engaging resident #001 rather than just watching over him/her. As well, because resident #006 makes gestures which could be misinterpreted by resident #001, the home should monitor resident #001's whereabouts and not leave resident #006 unsupervised in the hallway.

Interview with the ADOC and DOC confirmed that resident #006 was not capable to consent to an identified activity and the incident as described in the identified CIR was a form of abuse. Both the DOC and ADOC confirmed that more of the recommendations in the Ontario Shores report could have been implemented but due to resident #001's apparent progress as evidenced by very few instances of inappropriate behaviours in the

months of December 2016 and January 2017, they were not. The home was moving forward with further assessment from a psychiatrist and implementing the home's own Behavioural Support Services.

Previous inspection report #2016_321501_0019 and compliance order submitted to the home November 16, 2107, found resident #001 had abused seven residents from the period April to September 2016, in at least 39 documented instances, two of which involved resident #006. Due to the severity of harm being potential, the scope being isolated and ongoing noncompliance in the same area, a compliance order is being served. [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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Review of an identified CIR revealed Personal Support Worker (PSW) #006 reported to Registered Practical Nurse (RPN) #010 that he/she witnessed resident #001 in resident #006's room acting inappropriately. Resident #006 was sitting in his/her wheel-chair at the time. Interview with the DOC confirmed that because resident #006 was unable to consent to this activity, it was considered an act of abuse.

A report from Ontario Shores that included a Geriatric and Neuropsychiatry Outpatient (GNOS) Assessment regarding resident #001 was faxed to the home on an identified date. The report revealed several care recommendations and one recommendation was to consider the use of a medication.

Interview with resident #001's physician revealed he/she was not made aware of this report and recommendation for medication until after the incident on an identified date which was when he/she initiated a low dose of the medication. The physician was not aware of any other behavioural incidents involving resident #001 and was only loosely told of his/her previous inappropriate behaviours. The physician was unable to confirm whether having read the report would have changed the outcome as he/she may have wanted to wait and see if the environmental recommendations were successful before introducing medication.

Interview with the DOC revealed the home received the report on an identified date, and the nursing staff had updated the plan of care. The DOC confirmed the home failed to provide the physician with a copy of this report until after the incident, and had therefore not collaborated with the resident's physician in order to ensure their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interviews with PSW #005 and #006 revealed it is difficult to monitor residents with responsive behaviours and be patient with them when they often work short staffed or work with staff members who are doing double shifts. Interviews with RN #008 and RPN #010 confirmed that the home often works short staffed which makes it difficult to protect vulnerable residents from those with responsive behaviours. According to RPN #010, resident #001 often wanders and goes into other resident rooms when staff are busy giving care.

Interview with the ADOC revealed the home currently has 68 residents with responsive behaviours (representing 57 per cent of the resident population) of which 14 require enhanced monitoring. Interview with the Administrator revealed there were 111 hours that PSWs worked short staffed and 8 shifts that PSWs worked doubles in the month of February 2017.

Interviews with the ADOC, DOC and Administrator revealed they recognized staffing was an issue and have recently hired many new staff members. Interview with the Administrator confirmed the home has never evaluated their staffing plan but plan to do so this coming year. [s. 31. (3)]

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 staffing plan gets evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 17th day of March, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN SEMEREDY (501)
Inspection No. / No de l'inspection :	2017_626501_0004
Log No. / Registre no:	003953-17, 004324-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 9, 2017
Licensee / Titulaire de permis :	ATK CARE INC. 1386 INDIAN GROVE, MISSISSAUGA, ON, L5H-2S6
LTC Home / Foyer de SLD :	RIVER GLEN HAVEN NURSING HOME 160 High Street, P.O. Box 368, Sutton West, ON, L0E-1R0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ryan

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall protect all residents by demonstrating that the home has considered recommended interventions from Behaviour Support Services and any other consulting agency with the intent to eliminate the recurrence of abusive behaviour by resident #001 toward residents who are unable to consent.

Grounds / Motifs :

1. The licensee has failed to protect resident #006 from abuse.

One type of abuse as outlined in section 2.(1) of the Regulation (O.Reg.79/10) means any non-consensual touching, behavior or remarks of an identified nature or exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified date, a complaint was received by the MOHLTC INFOLINE indicating the home is not protecting residents from the identified abuse of resident #001. On an identified date, a Registered Nurse (RN) had informed the MOHLTC that resident #001 was found in resident #006's room acting inappropriately towards him/her.

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CIR.

Review of progress notes revealed resident #001 had acted inappropriately with resident #006 in the hallway on an identified date, and when the SDM was contacted he/she was noted to say that he/she was okay if someone acted in the identified manner toward his/her mother/father as long as it happens in a public area and not in his/her room. Interviews with RPN #010, PSW #005, and RN #009 revealed resident #006 often makes identified gestures to everyone and RN #009 and RN#008 confirmed resident #006 is not capable to consent to an identified activity. Interview with resident #006's SDM revealed that he/she was not concerned before but now that resident #001 has gone into his/her room he/she is worried because resident #006 could not say no.

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Review of a report from Ontario Shores that was faxed to the home on an identified date, revealed several care recommendations. One of the recommendations was to consider the use of an identified type of medication. Interview with resident #001's physician revealed he/she was not made aware of this report and recommendation for medication until after the incident, which was when he/she initiated a low dose of the medication. In addition, the report recommended implementing a healthy sleeping pattern at night time and engaging him/her in tasks that make him feel as though he/she is being helpful. Review of progress notes for resident #001 revealed there was no indication that sleeping medications were being adjusted until an identified date, and engaging the resident with helpful tasks had not yet been set up as a routine.

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Interview with the ADOC and DOC confirmed that resident #006 was not capable to consent to an identified activity and the incident as described in the identified CIR was a form of abuse. Both the DOC and ADOC confirmed that more of the recommendations in the Ontario Shores report could have been implemented but due to resident #001's apparent progress as evidenced by very few instances of inappropriate behaviours in the months of December 2016 and January 2017, they were not. The home was moving forward with further assessment from a psychiatrist and implementing the home's own Behavioural Support Services.

Previous inspection report #2016_321501_0019 and compliance order submitted to the home November 16, 2107, found resident #001 had abused seven residents from the period April to September 2016, in at least 39 documented instances, two of which involved resident #006. Due to the severity of harm being potential, the scope being isolated and ongoing noncompliance in the same area, a compliance order is being served. (501)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 20, 2017

REVIEW/APPEAL 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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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.

Issued on this 9th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Semeredy

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