Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

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33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 10, 2020	2020_748653_0010	002570-20	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

ROMELA VILLASPIR (653)

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): May 11, 12, 20, 21, 22, 25, and 26, 2020.

During the course of the inspection, Critical Incident System (CIS) Log #002570-20 related to allegation of staff to resident abuse, was inspected.

During the course of the inspection, the inspector reviewed clinical health records, staff training records, the home's investigation notes, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Worker (PSW), Registered Nurse (RN), and the Director of Care (DOC).

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.
2 WN(s)
1 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	Légende 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 #001, #002, #003, and #004, were protected from abuse by anyone in the home.

The home submitted a Critical Incident Report (CIR) for staff to resident abuse. The CIR indicated the Director of Care (DOC) received a written complaint from PSW #100 expressing concerns about the treatment of residents by PSW #101 while they performed care rounds together during their shift.

A review of PSW #100's written complaint and an interview with PSW #100 indicated that PSW #101 abused residents #001, #002, #003, and #004. PSW #100 further indicated that the incidents of abuse by PSW #101 towards the above mentioned residents, happened more than once in a span of approximately 18 months. PSW #100 indicated they did not immediately report the incidents of abuse to their supervisor due to being fearful of PSW #101.

An interview with the DOC indicated that after being made aware of the allegation of abuse, an investigation was immediately initiated, and PSW #101 was put on administrative leave. The DOC stated once they had determined in their investigation that abuse had taken place, PSW #101 was terminated. The DOC further indicated as per the police, charges were laid against PSW #101.

The licensee has failed to protect residents #001, #002, #003, and #004, from abuse. The witness failed to report the abuse in fear of retaliation from the abuser. The witness admitted that the actions constituted abuse, and decided not to report and instead, allowed the abuse to continue for up to 18 months before reporting to the management. [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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy titled "Abuse and Neglect" #RCSM P-10, reviewed on October 1, 2019, indicated that "All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator".

An interview with PSW #100 indicated that the incidents of abuse by PSW #101 towards residents #001, #002, #003, and #004, happened more than once in a span of approximately 18 months. PSW #100 indicated they did not immediately report the incidents of abuse to their supervisor due to being fearful of PSW #101. PSW #100 acknowledged they did not comply with the home's policy on abuse.

An interview with the DOC acknowledged that PSW #100 did not immediately report the incidents of staff to resident abuse to their supervisor, and acknowledged that the home's policy on abuse was not complied with. [s. 20. (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 without in any way restricting the generality of the duty provided for in section 19, that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

Issued on this 11th day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	ROMELA VILLASPIR (653)
Inspection No. / No de l’inspection :	2020_748653_0010
Log No. / No de registre :	002570-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 10, 2020
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 # / No d'ordre : 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. 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 must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall prepare, submit, and implement a written plan which includes but is not limited to the following elements for all direct care staff:

1. Training on the home's policy to promote zero tolerance of abuse and neglect of residents including but not limited to:
-Definitions of abuse and neglect.
-The duty under section 24 to make mandatory reports.
-Staff's responsibilities when abuse has been witnessed.
-Reporting abuse and the consequences for failing to report abuse.
-Whistle-blowing protections.

2. Develop an auditing or feedback process to ensure knowledge and understanding by all direct care staff of item #1.

3. The plan will identify persons responsible for implementing components of the plan, and timelines of implementation.

The plan is to be submitted by e-mail referencing report #2020_748653_0010 to Romela Villaspir, LTC Homes Inspector, MLTC, by June25, 2020, and implemented by October 26, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #001, #002, #003, and #004, were protected from abuse by anyone in the home.

The home submitted a Critical Incident Report (CIR) for staff to resident abuse. The CIR indicated the Director of Care (DOC) received a written complaint from PSW #100 expressing concerns about the treatment of residents by PSW #101 while they performed care rounds together during their shift.

A review of PSW #100's written complaint and an interview with PSW #100 indicated that PSW #101 abused residents #001, #002, #003, and #004. PSW #100 further indicated that the incidents of abuse by PSW #101 towards the above mentioned residents, happened more than once in a span of approximately 18 months. PSW #100 indicated they did not immediately report the incidents of abuse to their supervisor due to being fearful of PSW #101.

An interview with the DOC indicated that after being made aware of the allegation of abuse, an investigation was immediately initiated, and PSW #101 was put on administrative leave. The DOC stated once they had determined in their investigation that abuse had taken place, PSW #101 was terminated. The DOC further indicated as per the police, charges were laid against PSW #101.

The licensee has failed to protect residents #001, #002, #003, and #004, from abuse. The witness failed to report the abuse in fear of retaliation from the abuser. The witness admitted that the actions constituted abuse, and decided not to report and instead, allowed the abuse to continue for up to 18 months before reporting to the management.

The severity of this issue was determined to be a level 2 as there was minimal harm to residents #001, #002, #003, and #004. The scope of the issue was a level 3 as it related to four of four residents reviewed. The home had a level 3 compliance history as they had related non-compliance with this section of the LTCHA in the last 36 months, that included:
-A Director's Referral issued September 25, 2017 (2017_370649_0014);
-A Compliance Order issued July 16, 2018 (2018_718604_0002);
-A Written Notification issued October 10, 2019 (2019_684604_0020). (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 26, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of June, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

Service Area Office / Bureau régional de services : Central East Service Area Office